

**Report of the Task Force  
“To Advise the National Rural Health Mission  
on Strategies for Urban Health Care”**

**Ministry of Health & Family Welfare  
Government of India, New Delhi**

**June 2006**

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on Strategies for Urban Health Care"**

**Area Projects Division**

**Ministry of Health & Family Welfare  
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## Acronyms/Abbreviations used

ADB	-	Asian Development Bank
AFB	-	Acid Fast Bacilli
AIDS	-	Acquired Immuno-Deficiency Syndrome
AP	-	Area Projects
ANC	-	Antenatal Care
AP Division	-	Area Projects Division
ARI	-	Acute Respiratory Infection
ANM	-	Auxiliary Nurse Midwife
ASHA	-	Accredited Social Health Activist
AWC	-	Anganwadi Centre
AWW	-	Anganwadi Worker
BCC	-	Behaviour Change Communication
CBO	-	Community Based Organization
CDS	-	Community Development Society
CHC	-	Community Health Centre
DA	-	Daily Allowance
DC	-	Deputy Commissioner
DDK	-	Disposable Delivery Kit
DFID	-	Department for International Development
DGR	-	Decadal Growth Rate
DHS	-	District Health Society
DHM	-	District Health Mission
DIO	-	District Immunization Officer
DUDA	-	District Urban Development Authority
EAG	-	Empowered Action Group
DWCUA	-	Development of Women & Child in Urban Areas Scheme
EHP	-	Environmental Health Project
EmOC	-	Emergency Obstetrics Care
EPI	-	Expanded Programme of Immunization
FOGSI	-	Federation of Obstetrics &Gynaecological Societies of India
FRU	-	First Referral Unit
FW	-	Family Welfare
GOI	-	Government of India
HIV	-	Human Immuno-deficiency Virus
H&FW	-	Health & Family Welfare
HMIS	-	Health Management Information System
HP	-	Health Post
IAP	-	Indian Academy of Pediatrics
ICDS	-	Integrated Child Development Services
ID	-	Infrastructure Division
IEC	-	Information, Education & Communication
IFA	-	Iron Folic Acid
IHSDP	-	Integrated Housing & Slum Development Programme
IMA	-	Indian Medical Association
IMR	-	Infant Mortality Rate
IPHS	-	Indian Public Health Standards
IPP	-	India Population Project
IUD	-	Intra Uterine Device
JNNURM	-	Jawaharlal Nehru National Urban Renewal Mission
JSY	-	Janani Suraksha Yojna
LDC	-	Lower Divisional Clerk
LMO	-	Lady Medical Officer
LV	-	Link Volunteer
MAS	-	Mahila Arogya Samiti
MCD	-	Municipal Corporation of Delhi
MCH	-	Maternal & Child Health
MLA	-	Member of Legislative Assembly
MLC	-	Member of Legislative Council
MO	-	Medical Officer
MOHFW	-	Ministry of Health & Family Welfare, Govt. of India
MoUEPA	-	Ministry of Urban Employment & Poverty Alleviation, Govt. of India

MoUD	-	Ministry of Urban Development, Govt. of India
MOU	-	Memorandum of Understanding
MP	-	Member of Parliament
MTP	-	Medical Termination of Pregnancy
NAC	-	National Advisory Council
NACO	-	National AIDS Control Organization
NACP	-	National Aids Control Programme
NCMH	-	National Commission on Macroeconomics & Health
NFHS	-	National Family Health survey
NGO	-	Non Governmental Organization
NIHFW	-	National Institute of Health & Family Welfare
NHC	-	Neighbourhood Committee
NHG	-	Neighbourhood Group
NHP	-	National Health Policy
NLEP	-	National Leprosy Eradication Programme
NPP	-	National Population Policy
NRHM	-	National Rural Health Mission
NSDP	-	National Slum Development Programme
NSSO	-	National Sample Survey Organization
NUHM	-	National Urban Health Mission
NURM	-	National Urban Renewal Mission
ORS	-	Oral Rehydration Solution
OT	-	Operation Theatre
PDS	-	Public Distribution System
PHC	-	Primary Health Centre
PHN	-	Public Health Nurse
PIP	-	Programme Implementation Plan
PPP	-	Public Private Partnership
RCH	-	Reproductive & Child Health
RKS	-	Rogi Kalyan Samiti
RNTCP	-	Revised National Tuberculosis Control Programme
RTI	-	Reproductive Tract Infection
SACS	-	State AIDS Control Society
SIHFW	-	State Institute of Health & Family Welfare
SJSRY	-	Swarna Jayanti Shahari Rozgar Yojna
MD	-	Mission Directorate
SMO	-	Senior Medical Officer
STI	-	Sexually Transmitted Infection
SUDA	-	State Urban Development Authority
TA	-	Traveling Allowance
TOR	-	Terms of Reference
TT	-	Tetanus Toxoid
UD	-	Urban Development
UDC	-	Upper Divisional Clerk
UFWC	-	Urban Family Welfare Centre
UH	-	Urban Health
UHRC	-	Urban Health Resource Centre
UHC	-	Urban Health Centre
UHTF	-	Urban Health Task Force
ULB	-	Urban Local Body
UNICEF	-	United Nations Children's Fund
UNFPA	-	United Nations Population Fund
USAID	-	United States Agency for International Development
UT	-	Union Territory
VCTC	-	Voluntary Counseling & Testing Centre
WCD	-	Women & Child Development
WHC	-	Women's Health Committee
WHO	-	World Health Organization
ZH	-	Zonal Hospital

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## **Salient Features of Proposed National Urban Health Mission “A Snapshot View”**

- ❖ Seeks to address health needs of urban population of the country, with focus on slum (listed & unlisted) populations and other disadvantaged vulnerable sections.
- ❖ Proposes one Primary Level Health Facility (Urban Health Centre) per 50,000 population.
- ❖ Proposes one First Referral Level Health Facility (Zonal Hospital) per 250,000 population, with provision for establishment of new born care units.
- ❖ Envisages an active and socially committed slum level woman as “Link Volunteer” for a slum population of 1500-2000.
- ❖ Mandates regular outreach health services, directed at the Slum Population and other urban based vulnerable groups to proactively reach out to and address the problems of low access to health services by these sections.
- ❖ Supports training of Link Volunteers and Women’s Health Committees to carry out community health promotion activities in slums.
- ❖ Encourages enhanced role of Urban Local Bodies in provisioning of health care services in urban areas in the light of 74<sup>th</sup> Constitutional Amendment.
- ❖ Focuses on effective integration amongst Health and all Health related departments viz. Women & Child Development, Water & Sanitation, Urban Development/Urban Employment & Poverty Alleviation, Municipal Affairs, Nutrition, Education etc. and programmes like National Aids Control Programme.
- ❖ Proposes defined Institutional mechanisms and management systems for ensuring accountability at national, state, district and sub-district levels.
- ❖ Recommends decentralized city-specific planning, project formulation and implementation.
- ❖ Encourages optimal exploitation of Public Private Partnership (PPP) for expanding health services and strengthening linkages between the service providers and the community, especially the vulnerable sections thereof.

# Executive Summary

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## **Executive Summary**

### **1.0 Background**

- 1.1 The National Rural Health Mission (2005-12) was launched by the Hon' ble Prime Minister on 12<sup>th</sup> April 2005. The NRHM (2005-12) seeks to provide effective healthcare to rural population through out the country, with special focus on 18 states which have weak public health indicators and/or weak infrastructure. These 18 states are Arunachal Pradesh, Assam, Bihar, Chhattisgarh, Himachal Pradesh, Jharkhand, Jammu & Kashmir, Manipur, Mizoram, Meghalaya, Madhya Pradesh, Nagaland, Orissa, Rajasthan, Sikkim, Tripura, Uttaranchal and Uttar Pradesh.
- 1.2 The Mission is an articulation of the commitment of the government to raise public spending on health from 0.9% of GDP to 2-3% of GDP. It aims to undertake architectural correction of the health system to enable it to effectively handle increased allocations as promised under the National Common Minimum Programme and promote policies that strengthen public health management and service delivery in the country.
- 1.3 It seeks to revitalize local health traditions and mainstream AYUSH into the public health system. It aims at effective integration of health concerns with determinants of health like sanitation & hygiene, nutrition and safe drinking water through a district plan for health.
- 1.4 It seeks decentralization of programmes for district management of health. It seeks to address the inter-state and inter-district disparities, especially among the 18 high focus states, including unmet needs for public health infrastructure.

### **2.0 Constitution of Urban Health Task Force**

- 2.1 In order to effectively address health concerns of urban poor population, the Government of India constituted a Task Force in June 2005 to advise the National Rural Health Mission on strategies for urban health care. The Task Force met initially on 1<sup>st</sup> August 2005 and inter-alia constituted 2 subgroups, one each on "*UH Infrastructure & funds: Current availability and future requirement*" and "*Institutional framework for UH and coordination amongst stakeholders*". The Sub-Groups had one meeting each to deliberate upon the mandated issues.
- 2.2 In its second meeting held on November 25, 2005, the Task Force deliberated upon the recommendations of the Sub-Groups and after a series of informal discussions amongst the members subsequently (verbal and e-discussions), makes the following observations and recommendations as per its mandate.

### **3.0 Focused attention on Urban Health – An imperative requirement and need of the hour**

- 3.1 'Urban Health', being a relatively new and emerging priority for the Government of India, it imperatively and urgently requires a strong support, nurturing and backup from the Government (both Government of India and State Governments) to provide requisite motivation, impetus, back-up and levels of support, and momentum in all states.
- 3.2 A title such as '*National Rural Health Mission extended to urban areas*' may not correctly and comprehensively convey the government's envisaged intent and its associated focus with regard to Urban Health. The Task Force strongly recommends that Urban Health be given the status of an exclusive, stand alone entity (instead of being merely one of the components of the National Rural Health Mission) which should receive dedicated and priority attention of the concerned government agencies at all levels.
- 3.3 Unlike is the case with rural health, no conscious efforts and substantial investments have been made so far by either the central or state governments in so far as the issue of the urban health is concerned. To say it differently, urban health lags rural health by several decades, in the process creating a situation where these two entities viz. Urban Health and rural health are far more heterogeneous than homogenous. In view of this and also in the light of past experiences of the country in terms of the health sector, the task force feels that, should it be decided to have a broader National Health Mission (as compared to NRHM), comprising both the rural and urban components, the chances are, in practical terms, indeed high for urban health to be left to remain relegated to the background, as has been the case so far instead of receiving the long overdue and deserving attention.
- 3.4 Urban population in India has been rapidly growing, in fact at the rate faster than that of the rural areas. Simultaneously, over time, its share in the population of the country has also been steadily increasing. In 2001, the urban population accounted for 27.8% of the country's population. If population projections made by several agencies are anything to go by, it is expected that the proportion of India's urban population will rise to roughly 36% by 2026 and 44% by 2051. In such a scenario, it becomes imperative for the country to have a long term view and perspective planning to address the issues pertaining to Urban Health in a comprehensive, systematic and time-bound manner.
- 3.5 Therefore, the Task Force strongly recommends launching of an exclusive **National Urban Health Mission**, on the model/pattern of National Rural Health Mission launched by Government of India in April 2005 to facilitate required programme focus, fund allocation and specific accountability for effectively addressing the health needs of the urban population, in general and of the urban poor, in particular. This would also facilitate in ensuring that:
- The commitment of government to improve the quality of life of our citizens would be adequately met (25.7% poor live in urban areas), [Source: *National Human Development Report 2001*] is honoured in urban areas as well.

- Adequate focus is given at the Government level (GOI, States and City Level) to meet the health related challenges arising out of rapid growth of urban poor population due to natural causes as also other factors such as migration etc. These apart, there is also the dimension of progressively expanding city limits/boundaries which further adds to the size of the urban population whose health requirements would have to be catered to in the years to come.
- 3.6 The Task Force recommends that, states should develop their Urban Health Programme in a phased manner. States may be requested to prioritize the cities (for Urban Health projects) in the immediate phase, on the basis of the criterion of significant proportion of urban population living in poverty and/or an under-developed public health delivery network. The number of such selected cities should be such that the task remains manageable, achievable and effectively administrable. The number of such cities can grow gradually after sometime viz. after necessary technical capacity and adequate manpower get built up.
- 3.7 While the Task Force fully takes cognizance of the fact that the urban areas of the country as a whole require to be paid due attention to in so far as their health requirements are concerned, it feels that, in relative terms, the task which is much more imperative and urgent is that of specifically targeting the urban vulnerables, a majority of whom happen to reside in urban slums which are characterized by extremely unhygienic conditions and life threatening environments, not to talk of the other obvious implications of the high levels of the poverty that the urban slums are well known to suffer from. It was precisely on account of these factors that sometime back viz. February 2004, the Government of India had, on the basis of extensive stakeholders' consultations, had come out with "Guidelines for Development of City Level Urban Slum Health Projects"

#### 4.0 Definition of Slum

- 4.1 With a view to providing some sense of homogeneity and required levels of clarity and also for ensuring that no vulnerable sections of urban populace gets left out even inadvertently, after reviewing various available definitions of the term "Slum", the Task Force suggests the following definition.
- 4.2 In order to estimate the target population for the Urban Health Programme, the following definition of slums may be adhered to:
- 4.3 The definition of 'Slum' should be a proper combination of the description (a) used by the Population Census, 2001 and (b) National Slum Policy (Draft). Therefore, a habitation should be considered as 'Slum' **if it qualifies under any or more** of the following:
- I. All areas notified as 'Slum' by State/Local Government and UT Administration under any Act;
  - II. All areas recognized as 'Slum' by State/Local Government and UT Administration which have not been formally notified as slum under any Act;

- III. A compact area of at least 300 population or about 60-70 households of poorly built congested tenements, in unhygienic environments, usually with inadequate infrastructure and lacking in proper sanitary and drinking water facilities.
- IV. All under-served settlements, even if they be unauthorized occupation of land, congested inner-city built up areas, fringe areas, unauthorized developments, villages within urban areas and in the periphery, irrespective of tenure or ownership of land use shall be covered under the definition of a slum/informal urban poor settlement

## **5.0 Slum identification and its vulnerability assessment**

- 5.1 Slum identification/mapping and assessment of vulnerability would have to be carried out for developing Urban Health Programmes, in line with the steps outlined in the Guidelines (February 2004) for development of City-level Urban Slum Health Projects, issued earlier by Government of India. The concerned Government officials from Health and Urban Development Departments e.g. DUDA and other related/associated agencies should be actively involved in the process of identification and mapping of the slums (both notified and non-notified) and other urban poor habitations.
- 5.2 Suitable mechanisms and appropriate systemic arrangements have to be evolved, put in place and implemented for periodic updation (by an appropriate agency already existing or else to be created within the government system) of data/details concerning health and related aspects of urban areas.

## **6.0 Service delivery model**

- 6.1 The Task Force recommends that, for smaller towns and municipalities (with less than about 100,000 population), their health requirements should be catered to through appropriate provisioning in the district health plans utilizing the rural health infrastructure (viz. PHC/CHC etc.), and by providing necessary resources for undertaking outreach activities in the said urban areas. This needs to be well planned and provided for since over 30% of the urban population in the country lives in towns with a population of less than 100,000 (*Census, 2001*).
- 6.2 The Task Force recommends that in urban areas there should be a primary health care facility viz. an Urban Health Centre (UHC) for about every 50,000 population. All the existing primary health care facilities like dispensaries, D-Type Health Posts, Type-3 Urban Family Welfare Centres may be integrated into a uniform delivery mechanism, rechristened as 'Urban Health Centres'. All possible efforts may be made to locate the UHC within or else in close proximity to the slums concerned, with the focus laid in particular on the vulnerable group habitations. In such a pursuit, besides the listed slums, the unlisted ones also need to be covered through outreach as well as OPD services.
- 6.3 Although not in any substantial measure, the fact remains that at least to some extent, by virtue of certain governmental initiatives undertaken earlier, government created Urban Health infrastructure does exist in some

parts of the country. In view of this, whenever Urban Health planning is undertaken for such areas, due cognizance must be taken of the public health infrastructure already existing therein. Even while planning for required additional public health infrastructure in such areas, it must be ensured that all such existing urban health infrastructure (including the manpower component thereof), are effectively and optimally utilized rather than succumbing to the natural temptation of resorting to the option of unnecessarily creating new/additional infrastructure to compensate there for, since that would tantamount to cross subsidizing/incentivising inefficiency.

- 6.4 The Task Force recommends regular outreach services (as per predetermined monthly/fortnightly schedules) in the slums by ANMs to ensure *inter-alia* Antenatal Care, Childhood Immunization, promotion of birth spacing, treatment of minor ailments, health education, strengthening linkages with slum community etc.
- 6.5 The Second Tier Health Facility/FRU shall be, on an average, one for a population of about 2,50,000 which shall act as referral centre for 5 UHCs serving about 50,000 population each, within the catchment area of FRU. This network of one FRU and 5 UHCs shall constitute a 'Health Zone'. One (or more of so required) local NGO partner may be considered to undertake all community organization and IEC/BCC activities of the Health Zone.
- 6.6 The Task Force takes cognizance of the fact and totally endorses the principles of equity and gender, underlined and emphasized upon, among other things in the National Rural Health Mission. Arising out of this, it is suggested that, while planning for and implementing health programme in urban areas, it should be duly kept in view that the entity "women and children" is especially/relatively more vulnerable and should, therefore, be accorded special emphasis and due attention. In view of this it is recommended that the health bureaucracy, mission related personnel, medical and para-medical staff be adequately trained and sensitized.

## **7.0 Package of services**

- 7.1 The Task Force recommends that preventive, promotive and curative services be provided at first tier level, with a special focus on outreach services. Following is the suggested list/menu of services at first tier:
  - Antenatal care (early registration, TT immunization, IFA supplements, nutrition counseling, urine and blood examination, Physical examination of antenatal mothers including weighing, blood pressure, abdominal examination for position of the baby, identification of danger signs, referral for institutional deliveries)
  - Postnatal and post-abortion care
  - Child Health services, including breastfeeding, immunization, newborn care, management of diarrhoea & ARI, management of anaemia, Vitamin A supplementation

- Family planning services, including IUD insertion, referral for terminal methods
- Management of RTI/STI cases
- Management of malaria, tuberculosis, leprosy and other communicable diseases
- Laboratory services- Haemoglobin estimation, urine examination and urine pregnancy test; Peripheral Blood Smear for Malaria Parasite. Slit Skin Smear for Leprosy, Sputum Smear for AFB where possible.
- Treatment of minor ailments
- Depot holder services for contraceptive and ORS
- Counseling services for Adolescents, Family Planning, Nutrition, RTI/STI, HIV/AIDS, Mental Disorders and substance abuse
- Health check-ups in schools
- Behavioral Change Communication (BCC) Services/Awareness campaigns in the slums and vulnerable clusters

- Note :*
1. *The above package of Services is over and above the services being provided under Universal Immunization Programme, different schemes like JSY, and national disease control programmes like NAMP, RNTCP, NACP etc. as necessary provisioning for the urban areas as well have been made in the relevant national component*
  2. *Other services can be included in the package on the basis of the need and morbidity profile of the service area.*

7.2 The package of services at 'Regular Outreach Session' conducted by ANMs should *inter-alia* include Antenatal Check-up, TT Immunization, Childhood Immunization, distribution of IFA, Vitamin A, ORS Powder, Temporary contraceptives like OCPs, condoms, treatment of minor ailments, health education on different themes etc.

7.3 Apart from the services mentioned above for the first tier, the Task Force recommends the provision of the following health services at the second tier level:

- 24 Hour delivery services including normal and assisted
- Essential and emergency Obstetrics Care including surgical interventions like Caesarian Sections
- Full range of family planning services including laparoscopic services
- Essential and emergency newborn care
- Basic medical and surgical services

## **8.0 Community level activities**

8.1 Community level activities in urban slums shall primarily be carried out by Link Volunteers and Women's Groups, with coordination support from Non-Governmental Organizations.

### **8.2 Link Volunteers (LV)**

8.2.1 To develop and maintain an effective and demand-generating link between an urban health facility and the community, the UH Programme should envisage engagement of a social community worker called Link Volunteer, preferably a female from the slum community who should be able to spare at least a few hours (3-4 hours) a day on this pursuit. The Link Volunteer would cover approximately 250-350 households. The LV will receive performance based compensation *inter-alia* for promoting and assisting monthly outreach services for ANC and universal immunization, conducting monthly RCH behavior promotion meeting with slum women, promoting and supporting monthly meeting with Women's Health Groups, helping them record proceedings of such meetings, monitoring and tracking *inter-alia* coverage of TT, IFA, children's immunization, use of birth spacing methods, access to institutional deliveries, family planning services, referral and escort services for RCH and other health care delivery programmes. Wherever institutional arrangements for maternity services are inadequate vis-à-vis the demand, she may also promote and facilitate clean practices during home deliveries.

8.2.2 Link Volunteers could be identified, trained appropriately, mentored & supervised, and receive their entitled performance based compensation through designated Non-Governmental Organizations in their Health Zone (or part thereof). However, where such an arrangement is found infeasible, all possible efforts may be made by the concerned implementing agencies to encourage and promote/invoke NGOs in such an endeavor *inter-alia* by means of offering necessary support to them to initiate and participate in the health programme.

### **8.3 Women's Health Committee**

8.3.1 To expand the base of health promotion efforts at the community level and to build sustainable community processes, each Link Volunteer shall promote one or more women's group or Women's Health Committee in her own target area (of approximately 250-350 households).

## **9.0 Role of Urban Local Bodies**

9.1 The 74<sup>th</sup> Constitutional Amendment Act has transferred the management of health care facilities in urban areas to the Urban Local (Municipal) Bodies almost a decade back. However, the capacity of the Urban Local Bodies (ULBs) to lead, plan and manage UH Programme is not only limited in most

cases, but also varies from state to state; therefore the Task Force recommends that, depending upon the levels of involvement of the ULBs in the health related activities as also on the extent of decentralization, differential strategies be adopted on the lines mentioned below:

- 9.2 In the states where traditionally and over the years, the urban local bodies (ULBs) have been playing a substantial and significant role in provisioning of health care services, the Task Force recommends that the 'Mayor' or 'Chairperson' – Municipal Corporation can be made 'Co-Chairperson'; and Municipal Commissioner as 'Co-Convenor' of the Governing Body of District Health Society. The District Health Society may include a few more members viz. Chairpersons of other smaller Municipalities/Town Area Committees in District, Project Officer District Urban Development Agency (DUDA) and Municipal Health Officer/*Nagar Swasthya Adhikari* to its Governing Body. Similarly, it may also include Municipal Commissioner and Project Officer, DUDA and Municipal Health Officer/*Nagar Swasthya Adhikari* to the Executive Committee of District Health Society.
- 9.3 The primary UH infrastructure in the city be managed by the Urban Local Body, keeping the 'Ward' as the basic unit of planning and implementation. In the case of such states, the Task Force further recommends that the 'Slum' or 'Slum Cluster' Level Health, Water & Sanitation Committee (similar to the role envisaged for Village Health Committee in NRHM) be vested with the responsibility to guide all UH activities at the slum level. This committee will be responsible for developing the slum health plan, with the support of ANM, Link Volunteer, AWW (wherever present) and slum level community organizations (like *Basti Sudhar Samiti*). In the case of states in this category, the Task Force further recommends the strengthening of the health department/wing of the Municipality inter alia by devolution of funds and strengthening of Human Resources.
- 9.4 In the other states where traditionally and over the years, the urban local bodies (ULBs) have not been playing a substantial and significant role in provisioning of health care services, the states should take the lead in planning and implementing urban health programme and concurrently also take appropriate steps to gradually phase out the responsibility of managing UH infrastructure to ULBs.
- 9.5 In the case of States (for example, West Bengal) and in Metropolitan cities, where the Urban Local Bodies have been able to implement Urban Health Programme satisfactorily in the past, under an already functional institutional arrangement, the concerned states, if they so feel, may choose to continue with existing arrangements.
- 9.6 In the case of other States, where the Urban Local Bodies are still to develop into entities strong enough to efficiently manage the Urban Health Program/activities in their jurisdiction, even while doing all it takes, to enhance their professional and management (including financial) capacities to the required levels, till such time that happens, the Municipal Health Officer (or equivalent) and one or two elected representatives associated with the Health function of the ULB may be included as integral constituents viz. members of the District Urban Health Committee. The functioning of this committee may, in the interim, be coordinated by a Deputy CMO level

official of the Health Department with the District Magistrate as its Chairperson. As quickly as possible, and in a sustainable manner, in the medium/long term, the responsibility for formulating and implementing Urban Health Program may be handed over to the ULB in line with the provisions of the 74<sup>th</sup> Constitutional amendment.

- 9.7 Capacity building of the ward councilors in the areas of planning and management of UH care delivery services needs due attention to be paid. In these states, efforts should also be made to involve the 'Slum' or 'Slum Cluster' Level Health & Sanitation Committee in planning and guiding all UH activities at the slum level with the support of ANM, Link volunteer, AWW (wherever present) and slum level community organizations (like *Basti Sudhar Samiti*).

## **10.0 Institutional Framework for the implementation**

- 10.1** The Task Force recommends the following framework for the proposed National Urban Health Mission:

### **10.2 At the National level:**

**10.2.1** At the National level, the Mission Steering Group constituted under NRHM under the Chairmanship of Union Minister of Health & Family Welfare may provide the required policy guidance and operational oversight. Apart from concerned senior officials of the Union Ministry of Health & Family Welfare, Ministerial/Secretary level representatives of Union Ministry of Urban Development, Union Ministry of Urban Employment & Poverty Alleviation, and five urban health experts (preferably on biennial rotational basis) may be the members of Mission Steering Group.

**10.2.2** The Urban Health Mission Directorate may be headed by a Mission Director who is of the level of Additional Secretary to Government of India. Under the Mission Directorate, there may be five Joint Secretary level officers of the Government of India as members, whose roles and responsibilities need to be clearly defined.

**10.2.3** The Mission Directorate may be supported by an 'Urban Health Mission Secretariat' for execution of the directives and recommendations of Urban Health Mission Directorate.

### **10.3 At the State level:**

**10.3.1** At state level, the State Health Mission constituted under NRHM (Chaired by the Chief Minister, Co-chaired by Health & Family Welfare Minister and convened by the State Health & Family Welfare Secretary) may be suitably expanded to include proposed State Urban Health Mission Director as a member, and also provide for representation from Urban Health and related departments, NGOs and few Urban Health experts etc. However, wherever the

situation warrants, the States could make modifications in this regard appropriate to their context

**10.3.2** The State Health Society is responsible for planning and managing all health & family welfare programmes in the state both in the rural and urban areas. The Task Force recommends inclusion of some members from State Urban Development/Municipal Affairs Department, Department dealing with water supply and sanitation, Mayors/Municipal Commissioners from two to five cities of state on rotational basis (depending upon the size of the state), State Urban Health Mission Director and some experts from Urban Health field in the State Health Society. It may also be ensured through appropriate/enabling provisions that, whenever State Health Society meets for discharging its mandated functions, it will consider rural health and urban health issues as distinct/standalone entities, so that, along with Rural Health, Urban Health also receives the due and warranted attention of this Society. A separate Bank Account may be maintained of the Urban Health Programme at the state level.

**10.3.3** In line with the proposed Urban Health Mission Directorate at the national level, a "State Urban Health Mission Directorate" may be constituted at the state level for guiding, overseeing and directing Urban Health Programme in the state with a Commissioner/Secretary level officer as Mission Director.

**10.3.4** A State UH Mission Secretariat, with a 'Director' level official, assisted by Urban Health Consultant/s and secretarial staff would be responsible for carrying out the directives of the State UH Directorate and the day-to-day operations at the state level.

#### **10.4 At the District Level:**

**10.4.1** The District Health Mission in every district has an integrated District Health Society (DHS). The District Health Society shall be responsible for planning and managing all health & family welfare programmes in the district, covering both, the rural and urban areas. At District level, the over all policy directives and guidance to Urban Health Mission shall be given by District Health Society. Whenever District Health Society meets for discharging its required functions, DHS will pay attention to 'Rural' and 'Urban' health issues as distinct/standalone entities. A separate Bank Account may be maintained of the Urban Health Programme at the district level.

**10.4.2** Operationally, the District Urban Health Mission may function under District Urban Health Committee under the chairmanship of 'Mayor' of ULB. The following types of arrangement are suggested

- In the Mega cities, where the Urban Local Bodies are generally large and strong, following is the District Urban

Health Committee may function under the chairmanship of 'Mayor' of ULB.

- Medium to small cities with strong ULBs, the District Urban Health Committee may function under the chairmanship of 'Mayor' of ULB.
- However, in states where Urban Local Bodies are not strong enough in Medium to small cities the District Urban Health Committee may function under the chairmanship of the District Magistrate/Collector.

**10.4.3** The efficient functioning of this Directorate could be supported by a District Urban Health Secretariat, which can either be a separate unit or a part of existing District Programme Management Support Unit (DPMSU). Wherever Urban Health Cells already exist or else, as and when such cells get established, they can discharge the functions of such a Secretariat.

## **10.5 At Ward/Slum Cluster/Slum Level:**

**10.5.1A** Ward/Slum Cluster/Slum Level Health, Water and Sanitation Committee equivalent to Village Health Committee envisaged in NRHM may be constituted. This committee may have the involvement of government functionaries of the different concerned departments like WCD, water, sanitation, sewerage and drainage at the Ward/Slum Cluster/Slum Level.

**10.5.2** An association/collective of slum residents and officials for service delivery may be constituted at the slum level, as this is the basic unit for service delivery. This should ideally build on available platforms in the slums, wherever feasible.

## **11.0 Inter-Sectoral coordination**

**11.1** The Task Force recommends the following mechanisms for inter-sectoral coordination towards improvement of health status in slums:

**11.1.1** Convergence between Jawaharlal Nehru National Urban Renewal Mission (JNNURM) and National Urban Health Mission in select cities at City level; similarly, convergence between the Integrated Housing and Slum Development Programme (IHSDP) covering cities and towns not covered under JNNURM and National Urban Health Mission in the cities covered under IHSDP.

**11.1.2** Convergence between the elected body and city administration within National Urban Health Mission.

**11.1.3** Convergence between Department of Women & Child Development and DoHFW on use of field level workers (AWWs and Link Volunteers), prioritizing the setting up of Anganwadi Centres in vulnerable slums, developing MCH/RCH and adolescent health programmes jointly. In so far as the nutritional and primary health services are concerned the Anganwadi centers (especially where ever present in slums) may continue to remain as the venue/ operating base for community level activities.

**11.1.4** Level of convergence of activities between NACO/State AIDS Control Society and National UH Mission is left at the discretion of the state; however, the State AIDS Control Society should be actively involved in the UH Planning activity at the state level.

**11.1.5** Convergence in the field should be explored and exploited with agencies responsible for promoting Community Based Organizations (CBOs) in slums.

**11.1.6** Convergence with development partners such as USAID, UNICEF, UNFPA, DFID, ADB, World Bank in areas where they are already engaged actively or are planning activities concerning slum improvement.

**11.1.7** Health education and adolescent discussion forums should be developed as part of the school health programme through convergence with the Education Department.

## **12.0 Public Private Partnerships**

**12.1** The Task Force recommends that Public Private Partnerships (PPP) may be sought, explored and appropriately and optimally utilized in urban areas *inter-alia* for:

- Provision of primary health care services, including maternity, family planning and diagnostic services
- Enhancing service demand and behavioural change through Link Volunteers, IEC and BCC activities.
- Transport in case of emergencies and referrals
- Provision of second tier/referral services

**12.2** PPP model may be initiated for enhancing reach of services in at least one of the cities in each of the 18 high focus states of NRHM in the first year and subsequently expanded on this front, as required and feasible.

**12.3** The Task Force recommends that the Ministry of Health & Family Welfare, Government of India may take up the responsibility for documentation of best practices, lessons learnt and experiences of PPP for the better planning & implementation of programmes on health of the urban poor populations and for sharing the same with the States and other stakeholders to enable them to initiate and effectively implement PPP.

**12.4** The Task Force recommends that NGOs be encouraged and supported to get suitably involved in the planning and implementation of the urban health projects. The following options may be considered in so far as the functional domain is concerned:

- For undertaking situational analysis, identification and mapping of slums and other target beneficiaries, such as floating population, pavement dwellers and street children.

- In order to facilitate effective management and strong referral network in urban areas, it is proposed that 1 FRU and 5 UHCs may constitute a "Health Zone" i.e. for approximately 2,50,000 population. The Task Force suggests identifying one Field NGO for every Health Zone, which would primarily be involved in community organization, identification & capacity building of Link Volunteers and IEC/BCC activities.
- Supporting outreach clinics and linkage of services with slum communities.
- Management of Urban Health Centres, including OPD services and regular outreach services

However, where credible NGOs are not present, all possible efforts may be made by the concerned implementing agencies to encourage and promote/invoke NGOs in such an endeavor *inter-alia* by means of offering necessary support to them to initiate and participate in the health programme.

### **13.0 Monitoring & Evaluation**

- 1.1. A strong Monitoring and evaluation system based on scientific and systemic production, analysis and dissemination of health statistics, would ensure result based management of the urban health programmes.
- 1.2. Suitable mechanisms and appropriate systemic arrangements have to be evolved, put in place and implemented for periodic updation (by an appropriate agency already existing or else to be created within the government system) of data/details concerning health and related aspects of urban areas.
- 1.3. Community Level/based Monitoring is recommended at slum level using the framework and institutional mechanisms proposed under the NRHM. Emphasis would be laid on effective involvement of and participation of the concerned community (besides other stakeholders) at the stages of planning and programme implementation, and also in regular, periodic monitoring and evaluation exercises.
- 1.4. It is also recommended that suitable provisions be created whereby the ongoing urban health programmes will also be subjected to evaluation by certain independent/ external agencies with proven credentials for undertaking such evaluation exercises. State Urban Health Mission should plan and coordinate baseline survey (which can be outsourced to a suitable agency, if necessary) in identified cities. A total of 3 evaluations are to be conducted – (1) baseline, (2) midterm/concurrent and (3) end term surveys depending on the actual need in the state.

### **14.0 IEC/BCC activities**

- 14.1 Since conscious Urban Health efforts and initiatives in the country are of relatively recent origin, there is an enormous and imperative need to have very strong well thought out /articulated and well executed public education and advocacy campaigns in the context of "Urban Health". The proposed Urban Health Mission, in various cities and urban areas of the

country should also provide the requisite public health leadership and facilitate awareness campaigns

- 14.2 Demand generation IEC activities should be designed specifically to facilitate behavior change, particularly for adoption of family planning methods as well as other maternal, child health and adolescent health behaviors that are directly linked to RCH objectives. A strategy for IEC/BCC should be developed based on the local situation.
- 14.3 Private sector and NGO partnerships for IEC may also be promoted, particularly where potential partners with skills and proven experience and credentials in IEC/BCC are available. The IEC plans should especially focus on interpersonal or group communication plans, include a description of expected behavior change in different audience segments, and an outline of an IEC plan, with benchmarks for monitoring implementation and estimated budget.
- 14.4 Involvement of local level caste and religion based social groups who have their presence in most of the slums should be a critical element of the strategy. These groups could be utilised to disseminate key maternal and child health messages at community level.

## **15.0 Documentation & dissemination**

- 15.1 The MOHFW, GoI may ensure that the best practices, success stories and lessons learnt from urban Health projects as also urban health related data are comprehensively documented, updated periodically and shared with State Governments and other concerned stakeholders. It would also ensure that models based on PPP approaches are also documented for cross learning. These documents and data/information may also be hosted on the MOHFW, GOI's website for wider dissemination and optimal use by all concerned.
- 15.2 UH Guidelines of the Government of India may be adopted as much as possible and the states may plan and implement Urban Health programmes as per the applicable guidelines to the extent possible, with local adaptations, as may be required, with due justifications.
- 15.3 Sample Urban Health Proposals commissioned by Government of India are some good examples of bottom-up planning. They could be disseminated widely to provide concrete examples of some possible & useful practical approaches and strategies to improve Urban Health infrastructure, services and promotion of optimal behaviours.

## **16.0 Fund allocation for Urban Health**

An estimated total allocation of Rs. 9,301 crores for 5 years comprising Rs. 3250 crores in the first year and Rs. 6051 crores in next 4 years from the Centre to the States may be required to enable adequate focus on urban health (refer to *Box - 1* and *Appendix - 1* for the basis of computation of these figures). The allocation may be reviewed subsequently mid-course and appropriate adjustments made, if and when required. As mentioned earlier, the above mentioned fund is meant to cover only all the cities/towns having a population of 1,00,000 or more. This includes funds towards (a) programme management cost, (b) planning and situational analysis, (c) Capacity building activities and (d) Research, Documentation and dissemination.

- 16.1** The proposed Urban Health Mission budget is meant to complement the already created/existing Urban Health infrastructure and to improve efficacy of schemes of Government of India such as Janani Suraksha Yojna and Immunization where provisions are already available for rural and urban areas. Also, these budget estimates do not provide allocations for various disease specific National Health Programmes such as RNTCP, NLEP, NACP, National Programme for Control of Blindness, National Anti Malaria Programme, Iodine Deficiency Disorder Control Programme etc. for which budgetary provisions have been already kept under NRHM for both rural and urban areas.
- 16.2** For keeping clear accountability and transparency; and to facilitate tracking of program progress from time to time, it is recommended to maintain independent, clearly specified budget lines and separate books of account for rural health and urban health at National, State and District level.
- 16.3** The state Governments are being advised to go in for exclusive/dedicated UH projects for only those identified and prioritized urban areas having a population of more than 100,000. However, as per Census 2001, about 110.66 million people live in towns having less than 100,000 population. Hence, with a view to ensuring that the aforesaid large chunk of urban population does not get left out inadvertently, the Task Force recommends provisioning of health care services to this population through the rural health component of NRHM.

## **17 Sustainability**

- 17.1** Mechanisms for cost recovery may be built as an integral part into the proposal based on the principle of inclusion of the poorest. A corpus fund can also be created for sustaining the Project activities after the project period. Such a fund can be built through several sources of contribution which *inter-alia* include: portion of user charges (from middle class and upper class families) from diagnostic services, surgeries etc. at second tier, registration fees/family health card charges from all families collected at first tier and during outreach camps, donations from business houses, individuals, banks etc., appropriation received from National Slum Development Programme of GOI (ULB can access 5 times the amount generated at local level by communities from NSDP), and portion of lease and rental income from Municipal or other Public sector buildings.
- 17.2** Another aspect that would be also important to ensure that all the committees, groups, institutional mechanisms created, as part of Urban Health endeavors, are sustained as viable entities even beyond the currently sanctioned tenure of proposed NUHM, by deploying appropriate methods. Enhancing the capacity of the Urban Local Body to plan and manage such programmes are some possible approaches towards sustainability.

## **18.0 Additional provisions for high focus states of NRHM**

- 18.1** The Task Force recommends that in order to strengthen the capacity and also speed up the implementation of urban health component in the 18 high focus states under the NRHM, such states be provided with required extra/additional funding for enhancing the planning and implementation

capacity, e.g. setting up of separate Urban Health Secretariat/Cell at State Government Level. Therefore, the advancement of urban health agenda in NRHM high-focus states is recommended through

- More frequent on site reviews by GOI
- Starting lead programmes in at least 1 or 2 cities in each of the NRHM high focus states within the first year, and scaling them up rapidly thereafter in the following years.

**18.2** Capacity Building of Urban Health Nodal officials from high-focus states may be coordinated from the MOHFW level through periodic regional workshops, intensive training and study tours. This is one of the most critical and urgent requirements to be addressed. The requisite technical support for this purpose may be drawn from the Area Projects Division of MOHFW and/or the Urban Health Resource Centre, which is Government of India designated nodal technical agency for the Urban Health Programme in the country.

## **19.0 Road Map to implement Urban Health Programme**

**19.1** Since, by and large, adequate capacity at the state and city level does not exist at present for planning and effectively implementing the urban health component, the Task Force suggests that Urban Health Programme be implemented in phased manner during the tenure of the National Urban Health Mission spanning a period of five years.

**19.2** The Area Projects Division of MOHFW,GOI and UHRC, Government of India's designated nodal technical agency for the Urban Health Programme would be available for providing necessary technical assistance (if and when needed) to State Governments in the formulation and implementation of UH Projects.

**19.3** The Task Force recommends that, to start with, only the cities with substantial urban population be taken up by the states for Urban Health project formulation and implementation.

### **19.4 Steps at the GOI level**

**19.4.1** Comprehensive and clear cut communication from GOI to the states, based on the government decision over the recommendations of this Task Force.

**19.4.2** Establishment of the Urban Health Mission Directorate & Secretariat and its strengthening, with placement of required number of consultants and other supporting staff on contractual basis.

**19.4.3** Organizing state/regional level capacity building workshops, from time to time, to help the states to acquire the required technical capacity to develop and implement their Urban Health action plans.

**19.4.4** Periodic review and intensive monitoring of processes of planning & implementation in the states; special attention for 18 high focus states of NRHM

**19.4.5** Document and disseminate UH programme experiences with the states in hard copy or in electronic form *viz.* (a) share examples of well formulated and well executed UH proposals of different types of cities, in various population size dimensions (b) approaches for conducting situational analyses of cities, (c) slum assessment and plotting and (d) experiences in regard to the operation of public private partnerships framework/ models for Urban Health

## **19.5 Steps at the State level**

**19.5.1** Clear communication from State to the Districts as per the directives of State Urban Health Mission

**19.5.2** Establishment of State Urban Health Mission Directorate/Secretariat and its strengthening, with placement of appropriate personnel

**19.5.3** Inclusion of suggested members from the Department of Urban Development/Municipal Affairs (or its equivalent) in State Health Society/State Health Mission.

**19.5.4** Identification of at least 2 districts for initiating the UH Programme in the first year on the basis of relevant objective indicators.

**19.5.5** Organizing State Level Capacity Building workshops for municipal officials in order to sensitize them on their enhanced role in the backdrop of 74<sup>th</sup> Constitutional Amendment

**19.5.6** Ensure incorporation of the Urban Health component in the District Health Plans RCH-II Programme Implementation Plan (PIP).

## **19.6 Steps at the District level for Developing Urban Health Proposal**

**19.6.1** Situational Analysis incorporating details of development indicators, health indicators, health facility survey and challenges in improving health care delivery

**19.6.2** Identification and mapping of slums and existing health facilities

- i. Collection of slum lists from all the concerned departments *viz.* ICDS, health, municipal corporation, Pulse Polio Programme etc.
- ii. Reconciliation & consolidation of above slum lists to one slum list
- iii. Consultation with the AWW, ANMs, Ward Councilors, Sanitary Inspectors for identifying unlisted slums

iv. Mapping of both, the listed and unlisted slums, indicating *inter alia* the health facilities

**19.6.3** Stakeholders consultations for sharing the situational analysis and identifying the options for improving the health care delivery services

**19.6.4** Development of UH proposals including budget

**19.6.5** Final review of the UH proposals at District and State level

**19.6.6** Incorporation of comments and advisories given by District and State level Urban Health Missions

# Report of the Task Force to Advise the National Rural Health Mission on Strategies for Urban Health Care

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## **1.0 Background**

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The National Rural Health Mission (2005-12) was launched by the Hon' ble Prime Minister on 12<sup>th</sup> April 2005 for providing integrated comprehensive Primary Health Care Services to the rural population of the country. The Mission has been launched through out the country, with a high focus on 18 states, including 8 EAG states (Uttar Pradesh, Bihar, Uttaranchal, Chhattisgarh, Madhya Pradesh, Rajasthan, Jharkhand and Orissa), 8 North Eastern States (Sikkim, Assam, Arunachal Pradesh, Nagaland, Manipur, Tripura, Meghalaya and Mizoram), Jammu & Kashmir and Himachal Pradesh.

The Mission aims to undertake architectural correction of the Health System to enable it to handle the increased allocation for Public Health, as promised under the National Common Minimum Programme of the United Progressive Alliance Government. It also aims to bridge gaps in rural health care through increased community ownership, decentralization of the programmes to the district level, inter-sectoral convergence and improved primary health care. The Mission aims to achieve the goals of the National Population Policy 2000 and National Health Policy 2002 through improved access to affordable, accountable and reliable Primary Health Services.

### **1.1 Constitution of Urban Health Task Force**

In order to effectively address health concerns of urban poor population, this Task Force was constituted by Government of India in June 2005 for advising National Rural Health Mission on strategies for urban health care. Appendix – 2 provides details of the composition and terms of reference (TOR) of the Task Force.

The Task Force met initially on 1<sup>st</sup> August 2005 and inter-alia constituted of 2 subgroups, one each on "*UH Infrastructure & funds: Current availability and future requirement*" and "*Institutional framework for UH and coordination amongst stakeholders*". Appendix -3 contains details of these subgroups along with their TORs. The 2 sub-groups met on August 11 and 30, 2005 respectively. The second meeting of Task Force on November 25, 2005 and a series of informal discussions amongst the members subsequently (verbal and e-discussions) paved the way for the formulation of this report of the Task Force.

The Task Force appreciates the significant role which has been and is being played in the context of urban health by the erstwhile Environmental Health Project (EHP), an outfit supported by USAID, which has since been renamed as Urban Health Resource Centre (UHRC).

The Task Force takes cognizance of the fact that the Area Projects Division, GOI along with the UHRC, which is the Government of India's designated nodal technical agency for the Urban Health Programme would continue to remain available for providing necessary technical assistance to State Governments in the formulation and implementation of UH Projects.

## 2.0 Introduction

In India, out of the total population of about 1027 million as on 1st March, 2001, about 742 million lived in rural areas and 286 million in urban areas. The net addition of population in rural areas during 1991-2001 has been to the tune of 113 million, while in urban areas it was about 6 million. The rate of decadal growth of population in rural and urban areas during the decade stood at 17.9 and 31.2 percent respectively.

The share of urban population in the total population of the country stood at 27.8 in 2001. The share of urban population in total population as per the 1991 Census (including interpolated population of Jammu & Kashmir where Census could not be conducted in 1991) was 25.7 percent.

Area	Population in 2001			Share of population (%)
	Persons	Males	Females	
India (Total)	1,028,737,436	532,223,090	496,514,346	-
Rural	742,617,747	381,668,992	360,948,755	72.2
Urban	286,119,689	150,554,098	135,565,591	27.8

Source: Census of India, 2001

### 2.1 Slum & Urban Poor

Various definitions are available in the country for the term "Slum" such as, for instance, those used for/by Population Census, National Slum Policy (Draft) and the National Sample Survey Organization (NSSO). However, Task Force to advise the NRHM on strategies on Urban Health Care has chosen to define "Slum" as follows:

#### Definition of Slum

The definition of 'Slum' should be a proper combination of the description (a) used by census 2001 and (b) National Slum Policy (Draft). Therefore, a habitation should be considered as 'Slum' **if it qualifies under any or more** of the following -

- I. All areas notified as 'Slum' by State/Local Government and UT Administration under any Act;
- II. All areas recognized as 'Slum' by State/Local Government and UT Administration which have not been formally notified as slum under any Act;
- III. A compact area of at least 300 population or about 60-70 households of poorly built congested tenements, in unhygienic environments, usually with inadequate infrastructure and lacking in proper sanitary and drinking water facilities.
- IV. All under-served settlements, even if they be unauthorized occupation of land, congested inner-city built up areas, fringe areas, unauthorized developments, villages within urban areas and in the periphery, irrespective of tenure or ownership of land use shall be covered under the definition of a slum/informal urban poor settlement.

## **2.2 Urbanization & Growth of Urban Population**

Rapid and unplanned urbanization has been a marked feature of Indian demography. The urban population of India in 2001 accounted for 27.8% of the total population equating to 286 millions<sup>1</sup>. This represents a hundredfold increase in the past century, and a 40% increase during the last decade. If urban India were to be considered as a separate country, it would have been the fourth largest in the world, after only China, India and the United States.

Population projections by several agencies indicate that, by 2025, India's urban population will grow to the order of about 660 million, with more than half of the total population living in urban areas. In 2001, there were 35 million plus cities and 393 cities in the country having a population above 100,000. It is estimated, in some quarters, that the number of million plus cities in India will grow to 51 by 2011 and 75 by 2021 AD. In addition, according to some estimates, by 2021, it is anticipated that there would be about 500 cities with a population of above 100,000<sup>2</sup> each. This spatial manifestation of urban growth poses several formidable challenges. In the decade 1991-2001, as the country's population grew at an average growth rate of about 2 per cent annually, Urban India grew at about 3 percent annually, mega cities at about 4 per cent annually and slum populations increased at around 5 percent annually. Demographers have described this demographic scenario of India as the 2-3-4-5 phenomenon<sup>3</sup>.

### **2.2.1 Magnitude of the Urban Poor**

During the decade 1991-2001, 23.6% of the urban population in the country was estimated to be poor i.e. their expenditure on consumption goods was less than Rs 454 per month<sup>4</sup>. However, these estimates do not reflect the true high/severe magnitude of urban poverty because of the "un-accounted" for and unrecognized squatter-settlements, floating population and other populations residing in inner-city areas, pavements, construction sites, urban fringes, etc. In India, the absolute number of urban poor and the share of poor people living in urban areas has been increasing over time; it is now estimated that there are now more than 90 million (Haddad et al, 99)<sup>5</sup> urban poor in the country, most of whom live in slums.

### **2.3 Primary Health Infrastructure in the Urban Areas**

It is a common knowledge that the urban health infrastructure in most cities is grossly inadequate to meet the ever-growing demands of the urban poor, with large sections of this population being, more often than not, left out, for one reason or the other. On an average, there is only one UFWC/HP per 148,413 urban population in 2001 (based on a total of 1954 UFWCs & Health Posts for 285 million population). Though under India Population Project VIII (IPP-8) (1993 to 2002), 531 new facilities were constructed and 661 facilities were upgraded/renovated in Bangalore, Delhi, Hyderabad and Kolkata<sup>6</sup>, however, such systematic efforts of urban health programming focused on slum dwellers have so far remained confined to a few cities only. Although about 30% of the poor live

<sup>1</sup> 2001 Census, Registrar General of India

<sup>2</sup> Sivaramakrishnan K,C. and Singh B.N, 2001, Urbanization, [www.planningcommission.nic.in/reports/sereport/ser/vision2025/urban.doc](http://www.planningcommission.nic.in/reports/sereport/ser/vision2025/urban.doc), accessed on 21 Sep 2004

<sup>3</sup> Chatterjee, G. 2002. Consensus versus confrontation: Local authorities and state agencies form partnerships with urban poor communities in Mumbai. Urban Secretariat, United Nations Human Settlements Programme. UNHABITAT

<sup>4</sup> National Sample Survey Organization, 55<sup>th</sup> round survey (1999-2000)

<sup>5</sup> Lawrence Haddad, Marie T. Ruel, and James L. Garrett, 1999, Are Urban Poverty and Under-nutrition Growing? Some Newly Assembled Evidence

<sup>6</sup> India Population Project –VIII. End Line Survey, 2003. Ministry of Health and Family Welfare and Institute for Research in Medical Statistics

in urban areas, most of the primary health care facilities in the country are located in rural areas. This has happened due to the rural focus of the health programmes and policies in the country thus far.

In addition to the limited infrastructure, at present, the required level of clarity does not exist with regard to the roles and accountability for providing services to the urban poor among the service providers. In the light of the above mentioned situation, the urban poor often end up accessing the plethora of non qualified private providers, with all the attendant/associated risks and complications which can arise there from.

Though the decade old 74<sup>th</sup> Constitutional Amendment Act (specially under 12<sup>th</sup> Schedule) transferred the management of health care facilities to the Urban Local (Municipal) Bodies, health care in India remains still highly federalized, with central funding. Management of primary health services by the Urban Local Bodies has largely been linked to their fiscal capacities as evident from the presence of a large number of health care facilities in bigger cities due to broader and stronger tax and revenue base of the ULBs, with the larger cities having relatively higher levels of support from the Municipal Corporations in comparison to the smaller cities and towns.

With a multitude of institutions, personnel and health infrastructure in the urban areas from the public, private, and voluntary sectors, serious restructuring of the urban health care delivery system is urgently and imperatively called for, particularly from the stand point of clear cut geographical assignment of responsibilities and strengthening of referral linkages.

#### **2.4 ICDS coverage in urban slums**

The Integrated Child Development Services Scheme is an important community based child health and nutrition programme run by the Department of Women and Child Welfare. A review of ICDS coverage in the country shows that, out of the 7,32,960 AWCs in 2005 in the country, only 62,640<sup>7</sup> are located in and serving the urban areas.

Past studies suggest that the communities, when stimulated appropriately, can be effective partners in improving the possibilities of survival and development of children. This linkage is generally weak in the country as a whole, and even more so in urban poor communities. The urban poor, owing to weaker social cohesion than rural communities and weaker community organization, in most areas suffer an added disadvantage in this regard. Experiences of some of the NGOs as well as government run UH Programmes have shown that a focus on building community-provider linkages through community based volunteers can help to improve the community demand and usage of primary services. It further improves adoption of desired health-seeking behaviour and practices by the community.

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<sup>7</sup> Status Report of ICDS as on 14.10.2005 obtained from Department of Women and Child Development, Ministry of HRD, Govt. of India, 2005

## 2.5 Health Scenario in the Urban Slums

So far, the so called "urban advantage" has invariably been evading the poor, though not by design or intent. Whenever and wherever infrastructure and services are lacking, urban settlements are amongst the world's most life threatening environments<sup>8</sup>. Inevitably, challenging living conditions undermine the capacity of care takers to provide optimal care for the estimated 2 million children born each year among the urban poor population (based on fertility rate of 3 for a population of 67 million).

Under-5, infant and neonatal mortality rates are considerably higher among the urban poor as compared to National and State averages<sup>9</sup>. Infant and child mortality rates, in some sense reflect the level of socio economic development and quality of life. These are useful indicators for monitoring and evaluating health programmes and policies. The survival patterns among the urban poor, and more so in the relatively less developed states, clearly point to the need for extra focus on this large segment of India's population. The urban poor neonate in India comes into the world with certain distinct disadvantages<sup>10</sup>: (a) almost 6 out of 10 are delivered at home in the slum environment; (b) about 50 % are likely to be Low Birth Weight; (c) only 18% are breast fed immediately after being born.

Despite physical proximity of private, charitable and public sector health facilities in urban areas, the urban poor neonate is often born in uninspiring, unhygienic and unhealthy surroundings. This calls for the need inter-alia to enhance skilled attendance at the time of delivery, through promotion of institutional deliveries and also through training of birth attendants in the community since home deliveries may continue to take place in sizeable numbers for a long time. It also points to the needed emphasis on improving household care of the urban neonate through community level behaviour promotion strategies.

Proximity to hospitals and health professionals, as well as presence of active NGOs in several cities presents a unique and powerful opportunity to provide improved neonatal care. More than half of India's urban poor children are underweight and/or stunted. In most States, under-nutrition among the urban poor is worse than that among rural areas.

This underscores the need for augmenting nutrition focused programmes such as ICDS, Mid-day meal scheme and PDS, with targeted strategies to reach the vulnerable sections of urban populations. Simultaneous efforts to better understand and address household level care of young children in urban areas are also required.

The reach and utilization of essential preventive health services by the urban poor is usually found to be painfully low. For instance a) about 60% of children are not completely immunized by year one of age; b) use of birth spacing methods is abjectly low at 4%; c) as few as only 3 out of every 10 children affected with diarrhea receive ORS<sup>11</sup>.

This scenario is reflective of the family's compromised ability to recover from the existing limiting environment, paucity of time to seek health care as parents/caretakers are usually daily wagers and often pre-occupied with the risk of eviction and struggle to

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<sup>8</sup> WHO (1999). "Creating healthy cities in 21st century", chapter 6 in David Satterthwaite (ed.). The Earthscan reader on Sustainable cities, Earthscan publications London.

<sup>9</sup> EHP, 2003: Re-analysis of NFHS 2, 1998-99, by Standard of Living Index

<sup>10</sup> Awasthi, S., Agarwal S., 2003; Determinants of Childhood Mortality and Morbidity in Urban Slums of India; Indian Pediatrics, 40(12): 1145-1161

<sup>11</sup> EHP, 2003: Re-analysis of NFHS 2, 1998-99, by Standard of Living Index

access basic services such as water and sanitation. This is further compounded by low health awareness.

The reach and effectiveness of health care and immunization services in particular in urban slums are strained by a number of challenges. There are a multitude of healthcare service providers such as the Municipality, Ministry of Health, Private Sector, NGOs etc, with ill defined roles and poor coordination. The range of health problems in urban areas demands integration of the poor as a priority into urban health planning and for RCH services. Poor sanitation services in urban slum settlements and high population density increases risks of disease transmission. Heterogeneity of slum dwellers, lack of common meeting area, fewer extended family connections and more women engaged in work away from home affect flow of information about health services and facilities<sup>12</sup>.

## **2.6 Water and Sanitation Services**

Access to good quality water supply and sanitation facilities among the urban poor is very poor; about half of urban poor households do not receive water supply and about two-thirds do not have a toilet.<sup>13</sup>

## **2.7 Objectives and key strategies of Urban Health Programme**

Since in relation to Rural Health, Urban Health has so far remained a far too long and far too neglected aspect of health in the country, with a view to ensuring that atleast from now onwards, it receives the necessary impetus, due and warranted attention and support of the government, the Task Force strongly recommends that there be an exclusive and dedicated Mission for urban health, directed exclusively at Urban Health issues.

## **2.8 Goal & Objectives**

**Goal:** To improve the health status of the urban poor community by provision of quality Primary Health Care Services, with a focus on RCH services to achieve population stabilization.

**Objectives:** The main objective of the programme is to provide an integrated and sustainable system for primary health care service delivery, with emphasis on improved Family Planning and Child Health services in the urban areas of the country, for urban poor living in slums, be they notified or otherwise and other health vulnerable groups living in urban areas.

## **2.9 Key Strategies**

Urban Health Projects for identified cities may *inter-alia* include the following key strategies:

- Improving access to Family Welfare (FW) and Maternal and Child Health (MCH) services through renovation/up-gradation and re-organization of existing facilities, redeployment of available staff from State and UT Governments' Health Department and ongoing programmes and schemes and establishing new facilities wherever inevitably required, with due justifications, with provision of furniture, equipment and need-based mobility support on hiring basis and utilizing trained female volunteers at the community level. Strengthening of existing urban health infrastructure at first tier and second tier to cover all slum areas and making them to function optimally.

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<sup>12</sup> Atkinson S, Cheyne J. Immunization in urban areas: issues and strategies. Bulletin of World Health Organization, 1994, 72 (2): 183 – 194

<sup>13</sup> EHP, 2003: Re-analysis of NFHS-II, 198-99 by Standard of Living Index

- Improving the quality of Family Welfare Services through supervisory, managerial, technical and interpersonal skills at all levels of health functionaries, including training of female volunteers to help outreach service delivery through pre-service, in-service and on-the-job training.
- Appropriately & optimally involving NGOs and the private sector in various aspects of urban primary health care delivery.
- Increasing the demand for family welfare services comprising modern contraceptive usage, adoption of terminal methods, delivery care and child health services such as immunization and new born care. This would be done through IEC activities and enhancing the participation of communities and municipal leaders, opinion makers and change agents in the design, implementation and supervision of the services.
- Promoting convergence of efforts among multiple stakeholders, including the private sector to improve the health conditions of the urban poor.
- Developing effective linkages between the communities and 1<sup>st</sup> tier service delivery point and between the 1<sup>st</sup> tier facility and referral units at 2<sup>nd</sup> tier.
- Strengthening Monitoring and Evaluation mechanisms

### **3.0 Service Delivery Model**

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Under the ongoing Programme of the Ministry of Health & Family Welfare, different types of primary health facilities such as Urban Family Welfare Centres (UFWCs) and Urban Health Posts (UHPs) are already functioning in different States/UTs. The Government of India is presently supporting 3299 beds under sterilization beds scheme, 1083 Urban Family Welfare Centres, 871 Health Posts. The Post Partum Centres (550 at district level and 1012 at sub-district level) supported till 31<sup>st</sup> March 2002 by GOI, are now being operated and funded by the State Governments, from out of their own resources.

In addition, some other programmes run by State Governments/Municipalities /NGOs/Private Sector are also available to provide Primary Health Care Services in urban areas. In view of the different nomenclatures and types of facilities, the Programme envisages implementation of a uniform service delivery model by (a) integration of the facilities run by State Governments/ Municipalities and other private agencies, (b) upgrading/strengthening of the existing infrastructure, and (c) establishing new facilities, whenever inevitably required in rented building as far as possible.

The following may be the guiding principles for the suggested service delivery model:

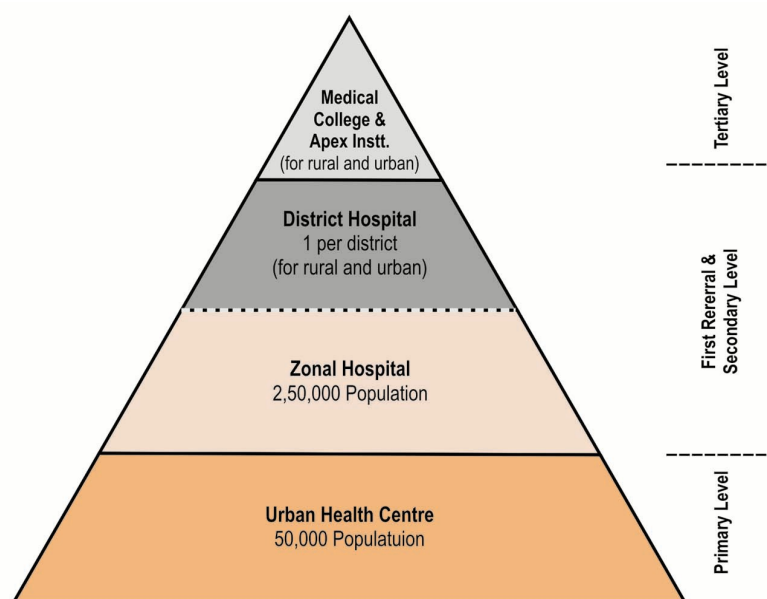
1. Although not in any substantial measure, the fact remains that at least to some extent, by virtue of certain governmental initiatives undertaken earlier, government created Urban Health infrastructure does exist in some parts of the country. In view of this, whenever Urban Health planning is undertaken for such areas, due cognizance must be taken of the public health infrastructure already existing therein. Even while planning for required additional public health infrastructure in such areas, it must be ensured that all such existing urban health infrastructure (including the manpower component thereof), are effectively and optimally utilized rather than succumbing to the natural temptation of resorting to the option of unnecessarily creating new/additional infrastructure to compensate there for, since that would tantamount to cross subsidizing/incentivising inefficiency.
2. Uniform service delivery model comprising service delivery at 3 tiers. Since most of the districts have relatively better secondary and tertiary level health facilities in comparison to primary level, the major focus of urban health programme shall be on primary level health facilities.

3. Revising the existing nomenclature like "Health Post" and "Urban Family Welfare Centres" as "Urban Health Centres" for the sake of uniformity.
4. Integrating health facilities managed by different stakeholders (especially state governments and municipalities).
5. Reorganizing and restructuring existing service delivery system to serve a defined geographical area for a defined population.
6. Establishing new facilities in rented buildings and going in for renovation/up-gradation of existing Government facilities as much as possible, rather than new constructions.
7. Using mobile vans for awareness generation, preventive and curative services for the target population wherever required.
8. Provision of hired/contracted ambulances for the safe transportation of the complicated cases from first tier to FRUs or from community to FRUs
9. Identifying potential private partners for first and second tiers and tapping them optimally for improving the quality of health care of the urban poor population by capitalizing on the skills and resources of potential partners.

### **3.1 Population Coverage for health facilities**

Though the programme envisages flexibilities in implementation of different service delivery models suiting local situations, the suggestive model is described as under:-

- The coverage population under one Urban Health Centre (UHC) would be about 50,000, out of which the size/magnitude of vulnerable population, for whom regular outreach services, are a dire necessity, is expected to be around 20,000-30,000, including listed and unlisted slums and other vulnerable community habitations. This norm may be suitably modified by the State/District UH Programme to ensure coverage and access and more so, utilization by the vulnerable populations of the services offered under the Urban Health Programme.
- The UHCs must ideally be located in the most vulnerable slums from health perspective or else, if unavoidable, these have to be located in close proximity of the slums concerned, or appropriately located in terms of physical location and operated to convenient timings for easy access by slum population within the catchment area.
- The second tier shall be a 24x7 health facility catering to approximately 2,50,000 population which shall provide referral for 5 primary level facilities. However, the actual requirement of second-tier facilities would depend on the population needs, existing facilities and the geographic spread of the existing cities. The State/District UH Programme may appropriately decide the requirement of second tier facilities in their respective state/district.
- The location of the UHCs and FRUs, and the area coverage under each should be indicated on the map.



## 3.2 First Tier Health Facility (Urban Health Centre)

### 3.2.1 Package of services

Preventive, promotive and curative services should be provided at first tier level, with a special focus on outreach services. Following is the suggested list of services at first tier:

- Antenatal care (early registration, TT immunization, IFA supplements, nutrition counseling, urine and blood examination, physical examination of antenatal mothers including weighing, blood pressure, abdominal examination for position of the baby, identification of danger signs, referral for institutional deliveries)
- Postnatal and post-abortion care
- Child Health services, including breastfeeding, immunization, newborn care, management of diarrhoea & ARI, management of anaemia, Vitamin A supplementation
- Family planning services, including IUD insertion, referral for terminal methods
- Management of RTI/STI cases
- Management of malaria, tuberculosis, leprosy and other communicable diseases
- Laboratory services- Haemoglobin estimation, urine examination and urine pregnancy test; Peripheral Blood Smear for Malaria Parasite. Slit Skin Smear for Leprosy, Sputum Smear for AFB where possible.
- Treatment of minor ailments
- Depot holder services for contraceptive and ORS
- Counseling services for Adolescents, Family Planning, Nutrition, RTI/STI, HIV/AIDS, Mental Disorders and substance abuse
- Health check-ups in schools
- Behavioral Change Communication (BCC) Services/Awareness campaigns

*Note: Other services can be included in the package on the basis of the need and morbidity profile of the service area.*

### 3.2.2 Timings of Urban Health Centre

Timings of UHC should be such that services can be made available to the target population at a time convenient to them. It is recommended that UHCs operate for 8 hours in a day. Each UHC may decide upon its timings, after assessing the needs and convenience of the slum/poor population which it is required to cater to.

States must decide on the appropriate timings (from clients' perspective) of Urban Health Centres in order to enhance the access to health care services by the urban poor population.

### 3.2.3 Human Resources for first tier

Based on the vulnerability levels of slums, existing facilities may be relocated to ensure adequate coverage of the marginalized settlements. All possible efforts should be made to effectively redeploy the existing staff from existing facilities of the State Government, Urban Local Body and ongoing programmes and schemes. Any new staff, if and where needed, could be taken through contractual arrangement, with the clear cut understanding and proviso that, in such an event, there will be absolutely no employer-employee relationship whatsoever between such contractual manpower and the government, both centre and state and that such appointees shall not be eligible for any of the entitlements available to regular government employees.

ANMs should be given an identified and clearly demarcated area for outreach services. Clear-cut roles and responsibilities should be defined for all staff to ensure their primary and exclusive utilization for delivering quality primary health care to the target population.

Following is the proposed human resource norms for a primary level health facility (Urban Health Centre):

Medical Officer (Preferably LMO)	-	1
Pharmacist	-	1
PHN/LHV	-	1
ANMs	-	4
Lab Technician	-	1
Computer Clerk cum Statistician	-	1
Chowkidar cum Peon	-	2
Sweeper	-	1
<b>TOTAL</b>	<b>-</b>	<b>12</b>

The Medical Officer (preferably a Lady Medical Officer) shall be in-charge of all the activities at UHC as well as in the field. There would be 4 ANMs posted at UHC, who will be assigned approximately 7,500 slum population each. The ANMs will make regular visit to their assigned slum areas. The PHN/LHV will supervise the activities of all the ANMs of UHC.

### 3.2.4 Support/Inputs to first tier

The financial support and interventions shall depend upon the specific projects received from the State Governments to meet the outlined objective of providing integrated primary health care & FW services in urban areas. However, the main activities/interventions to be considered for financial support to become an integral part of such projects could be as under:-

- Renovation/Up gradation of existing facilities
- Renting of accommodation for establishing new Urban Health Centres. This facility will include provision of space for services, office, minor OTs, Lab and storeroom for equipments etc. besides patient waiting area.
- New construction under the programme may be supported only in situations where government land is available for the construction

- Equipment & furniture for services to be provided from the urban health centre based on a facility survey for the existing facility and as per the standard list for the new facilities to be established
- Support for additional manpower on contractual basis, if inevitably required, with due justification only after appropriate deployment of the existing staff.
- Needs based drugs & supplies (excluding supplies being made under other programmes/schemes)
- Mobility support (hired vehicle for referral services, outreach clinics and other activities)

States shall also explore possibilities of initiating new UHCs in partnership with non governmental organizations.

### **3.3 Second tier health facility (Zonal Hospital)**

For each UHC catering to a specific population in a defined geographical area, options of 2<sup>nd</sup> tier facilities which can provide subsidized, affordable, and quality referral services should be identified, which may be public or private. It would be desirable to explore options to provide 2<sup>nd</sup> tier services through Private Nursing homes/Charitable Hospitals by entering into an agreement with them to provide services such as institutional deliveries, emergency obstetric care, terminal methods of family planning etc.

One second tier facility shall function as referral unit for 5 UHCs i.e. it shall cater to a population of approximately 2,50,000 population. This FRU along with 5 UHCs will constitute one 'Health Zone'. Therefore, the health facility at that level may be called 'Zonal Hospital'.

#### **3.3.1 Package of services**

Apart from the services of first tier facilities mentioned earlier (section 3.2.1), the second tier level should have the following services:

- 24 Hour delivery services including normal and assisted
- Essential and emergency Obstetrics Care including surgical interventions like Caesarian Sections
- Full range of family planning services including laparoscopic services
- Essential and emergency newborn care
- Basic medical and surgical services

#### **3.3.2 Timings of Second Tier Health Centre/Zonal Hospital**

The Zonal Hospital shall provide indoor and emergency services round the clock. However OPD services shall be given during morning and evening hours. States must further decide on the appropriate timings of OPD Services at Zonal Hospitals in order to enhance the access of health care services to the urban poor population.

#### **3.3.3 Human Resources for second tier**

Following is the proposed human resource norms for a secondary level health facility (Zonal Hospital):

Gynecologist	-	1
Paediatrician	-	1
Anaesthetist	-	1
Public Health Programme Manager	-	1
Medical Officer (MO)	-	3
Pharmacist	-	1
Staff Nurses	-	9

Lab Technician	-	1
Radiographer	-	1
Statistical Assistant cum Clerk	-	1
Ward Ayah/Nursing Orderly	-	3
OT Attendant	-	1
Sweepers	-	3
Chowkidar cum Peon	-	2
<b>TOTAL</b>	-	<b>29</b>

Note: One of the specialists mentioned above shall also function as Hospital Superintendent. States/Districts shall periodically review the staff positions and modify it somewhat if required. States shall explore keeping part time Anaesthetist on per case basis.

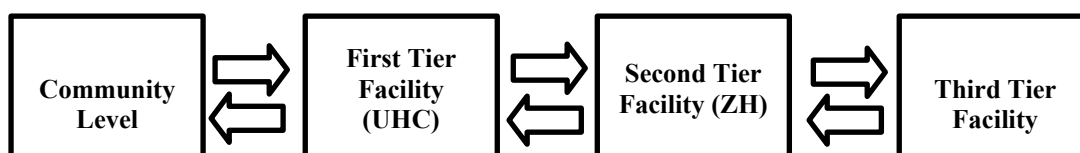
### 3.3.4 Support/Inputs to second tier (Zonal Hospital)

The main activities/interventions to be considered for financial support are outlined below.

- Renovation of existing referral facility or up-gradation of first tier facility shall essentially be the first choice. However, in circumstances where no such facilities exist, second tier facilities could be considered for construction.
- Support for need based additional add on/lab/Indoor facilities.
- Equipment & furniture for services to be provided from the referral centres (based on a facility survey for the existing referral facilities).
- Support for local contractual arrangements for part time Specialist/Medical Officer.
- Needs based drugs & supplies (over and above the supplies being made under other programmes/schemes)

The strengthening of 2<sup>nd</sup> tier facilities shall be in line with the CHC norms proposed under NRHM. Further, states may decide to strengthen them as per the availability of resources and essential requirements.

### 3.4 Mechanism of referral



Note: Good referral linkages are to be ensured between various tiers.

Establishment of an effective referral system will ensure that the secondary and tertiary levels of health care institutions are not needlessly burdened. For streamlining the referral mechanism, a 'Family Health Card' with a unique number could be made for every individual of the slum community. Providers at community level (Link Volunteer) and UHC level could issue such "Referral Card" which shall be honoured by the first and second tier service providers.

LVs should be trained on (a) recognition of danger signs and complications so as to timely detect health danger and know where to refer (to UHC or to Zonal Hospital) and (b) follow ups.

All UHCs must have a list of 2<sup>nd</sup> tier institutions where they would refer their patients. LVs will have to do the necessary follow up with referred patients and report to UHC.

Also procedures for establishing effective linkages of slum community with UHC through Link Volunteer shall be developed.

### **3.5 Quality of health services**

Indian Public Health Standards (IPHS) will be adopted for different levels of Urban Health facilities; In addition, suitable quality standards would have to be evolved specifically for Urban Health specific related dimensions not hitherto covered in IPHS.

### **3.6 Community Organization**

Community organization activities in urban slums shall primarily be carried out by Link Volunteer, Women's Group and Non-Governmental Organization.

#### **3.6.1 Link Volunteers (LV)**

To develop and maintain an effective and demand-generating link between health facility and the urban slum populations, the UH Programme envisages engagement of a social community worker called Link Volunteer, preferably a female from the same slum community who should be able to spare atleast about 3-4 hours in a day on this pursuit.

Several Programmes in the past have tried to lay down eligibility conditions for the link volunteer; however, it is stressed that as far as possible a female belonging to the same locality/slums who is well acceptable to the local community should be identified as Local Volunteer. She should preferably be engaged through/by local NGOs, in consultation with the community. The need for Link Volunteers should be reassessed<sup>14</sup> periodically. Possibilities should be explored to stabilize and integrate them with other slum development schemes/activities during the tenure of NUHM so as to make the system sustainable even after the completion of the mission period.

Link Volunteer will be an honorary worker, who will be the first port of call for any health related demands at slum/*Basti* level of the deprived vulnerable sections of the population; especially women and children who find it difficult to access health services for monetary and/or other reasons.

##### **3.6.1.1 Process of identification & selection of Link Volunteer**

The general norm to be followed will be "one Link Volunteer for every 250-350 households", which means approximately 1500-2000 population depending upon the geographical boundaries and vulnerability of the slum/slum cluster. However states can decide upon modifying it somewhat suitably, wherever warranted and justified.

The states will also need to work out the district and ward wise coverage/phasing of LVs. It is envisaged that the selection and training process of LVs will be given due attention by the concerned state to ensure at least 40% of the envisaged LVs, preferably from most vulnerable slums are selected and given induction training within first year. Rest of the LVs can be selected and trained during the subsequent year.

Link Volunteer (LV) must preferably be a women resident of the slum in question – married/widow/divorced in the age group of 25 to 45 years. She should have effective communication skills and leadership qualities, and be well accepted in the slum

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<sup>14</sup> Reassessment would be required to accommodate growth of the urban poor population and/or relocation of slum settlements

community. She should be a literate woman, with formal education of at least up to 8<sup>th</sup> class. This may be however relaxed in exceptional cases, if no suitable person with these qualifications is available for selection.

The selection of the LVs would have to be done in decentralized manner, with the active support and participation of communities concerned. For this purpose, the DHS, shall utilize the services of local NGOs with proven credentials; such an approach has been found effective in some states of our country such as Karnataka and Tamilnadu.

### **3.6.1.2 Roles & responsibilities of LV**

One LV may be given around 250-350 households in slum area covering approximately 1500 – 2000 population.

Link Volunteer will be a health activist in the community who will create awareness on health and its social determinants and mobilize the slum community towards local health planning and increased utilization and accountability of the existing health services. She would be an active promoter of good health practices. She will also provide a minimum package of curative care as appropriate and feasible for that level and make timely referrals.

- 1.** LV will identify target beneficiaries and support ANM in conducting regular outreach sessions and tracking service coverage. She would promote formation of Women's Health Groups in her community.
2. LV will take steps to create awareness and provide information to the community on determinants of health such as nutrition, basic sanitation & hygiene practices, healthy living and working conditions, information on existing health services and the need for timely utilization of health & family welfare services.
3. She will counsel women on birth preparedness, importance of safe delivery, breastfeeding and complementary feeding, immunization, contraception, prevention of common infections including RTIs/STIs, identification of anaemia, adolescent health and care of young child.
4. She will mobilize the community and facilitate them in accessing health and health related services available at the Anganwadi, Urban Health Centre and Zonal Hospital for the services like immunization, antenatal check-up, postnatal check-up, supplementary nutrition, sanitation and other services being provided by the government.
5. She will arrange escort/accompany pregnant women and children requiring treatment/admission to the nearest Urban Health Centre, secondary/tertiary level health care facility (Zonal Hospital/District Hospital/Speciality Hospital).
6. She will work with Health, Water and Sanitation Committee of the Slum/Slum Cluster for developing a comprehensive Slum/Slum Cluster health plan. She will also facilitate construction of community/household toilets under various Government of India schemes<sup>15</sup>.
7. She will act as depot holder for ORS Powder, Chlorine tablets/liquid, IFA tablets, Disposable Delivery Kits (DDKs), Oral Contraceptive Pills and condoms. Apart from this, a drug kit will also be provided for each LV. The contents of the kit will be based on the recommendations of an expert group to be set up by Government of India for this purpose.

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<sup>15</sup> VAMBAY and NSDP Schemes of Government of India

8. She will keep/maintain necessary information and records about births & deaths, immunization, antenatal services in her assigned locality as also about any unusual health problem or disease outbreak in the slum and share it with the ANM or UHC.

### **3.6.1.3 Compensation to Link Volunteer**

Link Volunteer would be a community volunteer who will receive performance based compensation *inter-alia* for promoting and assisting monthly outreach services for ANC and universal immunization, conducting monthly RCH behavior promotion meeting with slum women, promoting and supporting monthly meeting with Women's Health Groups, helping them record proceedings of such meetings, monitoring and tracking *inter-alia* coverage of TT, IFA, children's immunization, use of birth spacing methods, access to institutional deliveries, family planning services, referral and escort services for RCH and other health care delivery programmes. Wherever institutional arrangements are inadequate vis-à-vis the demand, she may also promote and facilitate clean practices during home deliveries. Link Volunteers could get their performance based compensation through Non-Governmental Organization of their Health Zone (or part thereof), in districts where NGOs are being involved as a partner in UH Programme.

Her work would be so tailored that it does not interfere with her normal livelihood. However, she should be suitably compensated additionally in the following situations:

1. For the duration of her training, in terms of both TA and DA so that her loss of wages for those days is at least partly compensated.
2. For participating in the monthly/bimonthly training, as the case may be.

### **3.6.1.4 Integration of Link Volunteer with ANM & AWW**

LV shall mobilize the women, girls and children from the slum community for orientation on health related issues such as importance of nutritious food, sanitation & personal hygiene, care during pregnancy, importance of antenatal check-up and institutional deliveries, importance of immunization etc during outreach sessions . ANM shall also act as resource person to LV.

She can further participate in IEC activities through display of posters, folk dances etc. on outreach session days. ANM should replenish LV's exhausted/depleted stock of contraceptives, IFA tablets, ORS Powder and DDK. LV shall help ANM/AWW in updating the list of eligible couples and children less than 1 year of age. She can further support AWW in mobilizing pregnant & lactating women and infants for nutritional supplement. She would also take initiatives for bringing the beneficiaries from the slum on specific days of immunization, health check-ups/health days etc. to Anganwadi Centers. Efforts should be made to ensure that the Link volunteer and the Anganwadi Worker of the concerned slum function in a sense of complementarity, supporting each other, rather than be unnecessarily duplicating their efforts, so as to avoid sub- optimal utilization of scare resources.

### **3.6.1.5 Federation of LVs**

Network of community health volunteers are known to be effective in lending greater strength to community provider linkages through their collective efforts. After a year or two, as the LVs are trained and strengthened with support of NGOs, such networks could be promoted around 1 or 2 health centres.

### **3.6.2 Women's Health Committee**

To expand the base of health promotion efforts at the community level and to build sustainable community processes, each Link Volunteer shall promote one or more women's group or Women's Health Committee in her own target area (of approximately 250-350 households).

Women's Health Committees can facilitate in furthering ownership of the health promotion process in the community. The community ownership can play pivotal role in bringing about the required change in attitudes and approaches to health behaviour.

Part of community ownership (thus) represents a cultural acceptance of health norms and health care-seeking behaviors, along with increased responsibilities of the community in health affairs. This is reflected, for example, in increased demand for health care services or health education, and an increased demand for health services on the basis of accountability relationships<sup>16</sup>, providing a base for sustainability in demand and community processes.

### **3.6.2.1 Process of promotion of Women's Health Committee**

Present or past experiences of collective efforts in the slums towards fulfillment of any objective will have to be explored. During this exercise, potential community leaders and target women will be identified and over a period of time, encouraged to work collectively on community issues to form the base of the Women's Health Committee. It may be borne in mind that each community responds differently and takes its own time to crystallize, and interventions would have to be designed, keeping in alignment with the community.

The suggested norm for one group is 15 members for about 250-350 families. The numbers will vary depending on the size of the slum (e.g. in case of a small slum with 100 families, the Committee will be promoted over 100 families) and also the factors within the slum (e.g. different communities within a small area).

### **3.6.2.2 Desired characteristics of members of Women's Health Committee**

Membership in the Women's Health Committee may be guided by the objectives and expected roles of this group. The membership in the group would be a natural process, rather than an external selection process. Therefore the following should not be seen as eligibility criteria. However the common features emerging in this scene would be –

- Woman with a desire to contribute to 'well-being of the community' and with a sense of social commitment and leadership skills.
- Woman's age is not being kept as a barrier as the role of the woman in the house and the community is either as a target beneficiary or as an influencing force.
- Any woman identified as a 'Dai' or as an 'informal' birth attendant, and recognized by the community.
- If a group is being formed over a number of pockets of different communities, membership from all such pockets shall be ensured.
- If the slum has a presence or history of collective efforts (as a self help group, DWCUA group, Neighborhood Group under SJSRY, thrift and credit group), women involved in these efforts should be encouraged.
- The link volunteer should be a member of this group. She should be conscious of her dual role in this context, and consciously encourage leadership.

### **3.6.2.3 Roles of the Women's Health Committee**

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<sup>16</sup> Eric Starriot, 2002, CSTS CORE Sustaining Child Survival: Many roads to choose but do we have a map?

The group could carry out the following roles with the support of the Link Volunteer. Roles and independence in execution of roles is expected to increase with ongoing capacity building inputs:

- Support link volunteer in tracking and monitoring coverage of key interventions such as TT and IFA consumption during pregnancy, childhood immunization and contraceptive usage.
- Motivate target women (pregnant women or mothers of young children) to collect for group counseling sessions in the slum
- Support outreach camps by ensuring presence of target group.
- The conveners or other designated representatives of the group along with the respective Link Volunteer will attend meetings held at the UHC and provide feedback on service delivery. This will enable the UHC staff to identify areas that require strengthening and will thus strengthen quality and reach (to the poor) of services.
- Collect, manage and utilize a Community Health Fund for meeting health emergencies in the slum and for sustaining health promotion efforts.
- Maintain BCC and IEC materials at a safe and easily accessible place in the community.

#### **3.6.2.4 Support to Women’s Health Committee**

A sum of Rs. 1500/- per annum has been budgeted for support to each Women’s Health Committee. In the initial stages, as the WHC takes shape, this amount shall be utilized for motivating and strengthening the WHC and enhancing its institutional capacities (e.g. provision of *durries*, box/cupboard, IEC/BCC materials etc.) Subsequently it may be used for supporting its financial requirements (travel for accompanying patients to referral units, contribution to health fund, other contingency costs).

#### **3.6.3 Non Governmental Organizations**

Partnership with NGOs has been listed as one of the strategic themes in NPP 2000. Often NGOs have a comparative advantage of flexibility in procedures and rapport with the local community. The GoI therefore proposes to involve NGOs in using strategies for expanding access to health services under RCH-II scheme.

In order to facilitate effective management and strong referral network in urban areas it is proposed that 1 FRU and 5 UHCs will constitute a “Health Zone” i.e. on approximately 2,50,000 population. The Task Force suggests identifying one Field NGO for every Health Zone, who would primarily be involved in community organization, capacity building and IEC/BCC activities. Following is the proposed human resource for the partner NGO in a Health Zone.

Zonal Coordinator	-	1
Social Mobilizer	-	5-6
Statistical Assistant cum Clerk	-	1
Administrative/Secretarial Staff	-	1

The Zonal Coordinator shall be responsible for the all community organization and IEC/BCC activities in the Zone. S/he would be supported by one Statistical Assistant cum Clerk, Administrative/Secretarial Staff and 5-6 Social Mobilizers. Each mobilizer shall be responsible for the slum level activities under one Urban Health Centre. Social mobilizers shall work in close coordination with ANMs and other UHC staff and provide support to LVs. If the situation so warrants inevitably, more than 1 NGO could be involved in one Zone on needs basis.

Apart from the above arrangement, the support for Link Volunteers and Women’s Health Committees can also be routed through NGO, going by the examples of the reasonably well functioning approach adopted in States like Karnataka, of NGOs being out-sourced

the responsibility for identifying, training, mentoring, supervising and managing performance based compensation of link volunteers. However, where such an arrangement is found infeasible, all possible efforts may be made by the concerned implementing agencies to encourage and promote/invoke NGOs in such an endeavor *inter-alia* by means of offering necessary support to them to initiate and participate in the health programme.

The details of budgetary provisions made for the NGOs are provided in the *Appendix - 1*. This apart, proactive effort may be made to engage credible NGOs in the management of UHCs, including OPD and outreach services, wherever feasible.

### **3.7 Community Level Activities**

The capacities of the Link Volunteer to facilitate health improvements in the community should be built through capacity building efforts by non-governmental organizations. Women's Health Groups are formed by the Link Volunteer to expand the base of health promotion efforts at the community level and to build sustainable community processes. Capacity building should focus on social mobilization, CBO promotion, BCC Skills apart from technical issues like Maternal and Child Family Planning, Health, adolescent health Malaria, Tuberculosis, , RTIs/STIs and HIV/AIDS so that Link Volunteers and Women's Health Committees are able to conjunctively promote modern contraceptive usage, immunization and other maternity and child health & survival practices.

The NGO should be encouraged to make an effort to stabilize Link Volunteers as well as Women's Health Groups through linkage with slum welfare schemes and to reduce dependence on programme funding over time. Activities should be aimed at fulfilling the unmet MCH and Family Planning needs of the community.

NGOs shall also facilitate health education and adolescent discussion forums as part of the school health programme through convergence with the Education Department.

### **3.8 Capacity Building/Training**

NGOs shall be responsible for all the capacity building activities of Link Volunteers and Women's Health Group in their Zone/area. Social Mobilizers should inform LV about the date, time and place for initial and subsequent trainings. NGOs shall also ensure that LV gets her entitled compensation for performance and also TA/DA for attending the trainings and essential meetings if any.

The different agencies involved in the implementation, management, and monitoring of the proposed Urban Health Programme would need training on a range of issues at different phases of the project to handle additional responsibilities and to develop skills to work towards desired impact.

Training requirements at various levels of implementing agencies should be identified and a capacity building plan proposed. Management capacities can include management skills, finance and accounts, evaluation and documentation skills. Programme capacities may include family planning services, child health and nutrition related technical skills, follow-up, monitoring and referrals, programme processes – counseling, community-based monitoring, participatory approaches, IEC and behaviour change and communication approaches, linkages with health service providers, etc. Public private partnerships for capacity building should be promoted, wherever possible.

### **3.9 Outreach Services**

Activities that reach out to the most vulnerable and the underserved should be planned as a means of increasing usage of critical health care services and for creating rapport with the community. A qualitative slum assessment conducted by each Social Mobilizer in his/her UHC area would help him/her to find out most vulnerable slums. The outreach plan should have a greater focus on the most vulnerable slum communities with poor health indicators. The composition of the outreach team and the frequency of outreach activities should be outlined. Mobility support for outreach activities should be provided for in the budget.

For outreach services, convenient "Outreach Points" (such as schools, community halls etc.) should be identified in consultation with the slum community. The aim is to locate a place where slum people feel comfortable, especially women and children.

Outreach services are broadly divided into 2 groups (1) Regular Outreach Sessions and (2) Outreach Clinics.

### **3.9.1 Regular Outreach Sessions**

ANMs shall carry out 'Outreach Sessions' in their assigned slums on regular basis. She should make her schedule in such a way that the 'Regular Outreach Sessions' are organized in each Basti/Link Volunteer's area on a fortnightly/monthly basis. Her functions are categorized into (1) Household level and (2) Slum/*Basti* Level. The household level work will include home visits of postnatal cases, follow up home visits to users of temporary contraceptives, especially oral pills and IUD, and to couples with unmet family planning needs, follow up visits to the cases that are referred for secondary and tertiary care, Group Counseling and BCC.

The Slum/*Basti* Level activities of ANM should include immunization, antenatal care, post-natal & post-abortion care and detection of postnatal complications, registration of births and deaths, counseling, BCC activities etc.

The package of services at 'Regular Outreach Session' conducted by ANMs should include Antenatal Check-up, TT Immunization, Childhood Immunization, distribution of IFA, Vitamin A, ORS Powder, Temporary contraceptives like OCPs, condoms, treatment of minor ailments, health education on different themes.

West Bengal model of Urban Health, where there is a presence of strong grass-root groups in the slum community; sustainability through user charges and training of slum based worker as 'Honorary Health care Worker' is, for example, a good model/specimen to get guided by. An effort should be made to replicate it in other parts of the country, with whatever suitable/ appropriate modifications as may be required by the specific local conditions and specific requirements of the concerned Urban Areas; community-provider linkages to be strengthened through LVs and their recognition at First tier level and FRU.

### **3.9.2 Outreach Clinics**

Outreach Clinics may be organized in the most vulnerable slums of the UHC catchment area by the UHC team in collaboration with NGO's Social Mobilizer, the Link Volunteer and the Women's Health Group. At these Clinics first contact curative services in the slums are to be provided by the Medical Officer.

The Outreach Clinics shall be conducted once in a month/fortnightly in the most and/or the moderately vulnerable slums. The Medical Officer and other UHC staff will develop a quarterly/half yearly schedule covering all the most vulnerable and moderately vulnerable sites in the area. If the need arises, the 'Outreach Clinics' might be organized every fortnight.

The package of services at the 'Outreach Clinics' would be aimed at 'Total Health' and it should *inter-alia* include – General Medical Care, Immunization, Family Planning Services, Antenatal/Post-Natal/Post-Abortion Services, treatment of RTI/STI cases, Health Education, Counseling and Referrals.

By way of mobility support, a vehicle can be hired by the UHCs on Clinic days. A vehicle will also deliver vaccines from the central office/District Immunization Office to all UHCs on vaccination days. A contract with the transporters can be worked out (if required) centrally at district level.

### **3.10 IEC/BCC and Social Mobilization Activities**

Since conscious Urban Health efforts and initiatives in the country are of relatively recent origin, there is an enormous and imperative need to have very strong well thought out /articulated and well executed public education and advocacy campaigns in the context of "Urban Health". The proposed Urban Health Mission, in various cities and urban areas of the country should also provide the requisite public health leadership and facilitate awareness campaigns directed at (a) involving municipal bodies in urban health efforts (b) educating slum communities about essential household behaviors conducive to health as also the importance of environmental hygiene and upkeep, (c) providing required awareness/ information regarding available health infrastructure and services,(d) implementing well designed school health education campaigns.

Health indicators of people living in slums are poor. Demand generation IEC activities should be designed specifically to facilitate behavior change, particularly for adoption of family planning methods as well as other maternal, child health and adolescent health behaviors that are directly linked to RCH objectives. It is suggested that strategies should (a) focus on IEC for behavior change in RCH; (b) establish linkages, and if necessary, enhance selected activities of other schemes that provide benefit to the project beneficiaries. A strategy for IEC/BCC should be developed based on the local situation.

Private sector and NGO partnerships for IEC may also be promoted, particularly where potential partners with skills and proven experience and credentials in IEC/BCC are available. The IEC plans should especially focus on interpersonal or group communication plans, include a description of expected behavior change in different audience segments, and an outline of an IEC plan, with benchmarks for monitoring implementation and estimated budget. IEC plans should focus on building community awareness and knowledge enhancing skills to practice healthy behaviors, and strengthening confidence to access health services.

#### **3.10.1 Strategies for IEC/BCC**

- A. Build awareness and knowledge to:
  - Awareness about health and disease and its social implications
  - Help community overcome misconceptions, misinformation, taboos, myths etc.
  - Increase awareness of the services provided and the referral system
  - Enhance skills and confidence to practice healthy behaviors
  - Strengthen motivation and confidence to access services
- B. Approaches would be –
  - Mass media approaches like Press, Radio, TV, Wall Paintings, Magic shows, Folk Media - Folk songs, Street Theatre etc.
  - Community events like awareness camps, *melas*, demonstrations, exhibitions, well baby shows, supporting National events (newborn week, breastfeeding week, nutrition week, World Aids Day etc.)

- C. Enhance skills and confidence to practice healthy behaviors through Counseling sessions – Group and individual counseling sessions; promote peer counselors;
- D. Strengthen eagerness and confidence to access services
  - Identifying and building capacity of WHC members and Link Volunteers.
  - Promoting and strengthening the groups in the slums.
  - Recognition of community representatives (Link Volunteers, and WHCs) as important stakeholders in health promotion, by encouraging them to voice community needs at UHC Coordination Forum meetings.
- E. Involve local level caste and religion based social groups who have their presence in most of the slums. These groups could be contacted to disseminate key maternal and child health messages at community level.

### **3.10.2 Key Issues for IEC/BCC**

#### **A. Programme areas**

- Details of Health care services: location of UHC, and Referral unit
- Relevance and roles of Women’s Health Committee

#### **B. Technical Areas**

- Family planning services
- Antenatal, delivery, postnatal and post abortion care
- New born care and Breastfeeding Practices
- Infant and Child health, immunization
- Diarrhea, ARI, Malaria & other communicable diseases

#### **C. Basic Information**

- Timings, services available from UHC and details of Outreach Clinics
- National and international events- such as Health & Nutrition Days, Nutrition week, Breastfeeding week, Newborn Week, World AIDS Day etc.

### **3.11 Enhancing the role of Medical Colleges & other institutions**

Medical Colleges are providing tertiary level health facilities at the place of their location. However, so far, regrettably, their awareness about and participation in Public Health Programmes, has been abysmally low. This malady has to be addressed efficiently and effectively in the interests of both – students and health programmes themselves. There is indeed a vast amount of untapped/under-tapped potential in this regard waiting to be exploited.

The medical colleges should be involved in the delivery of primary level health care through running UHCs, and piloting innovative strategies/various models, training and monitoring & evaluation. Every medical college can effectively run atleast 2-3 urban health centres.

National level institutions like NIHF, SIHF and other agencies with relevant experience in UH programming can play a lead role in building capacities of the programmers and implementers on Urban Health planning and implementation.

### **3.12 Documentation & dissemination of information on innovations, lessons learnt and best practices**

The MOHFW, GoI may ensure that the best practices, success stories and lessons learnt from urban Health projects as also urban health related data are comprehensively documented, updated periodically and shared with State Governments and other concerned stakeholders. It would also ensure that models based on PPP approaches are

also documented for cross learning. These documents and data/information may also be hosted on the MOHFW, GOI's website for wider dissemination and optimal use by all concerned.

UH Guidelines of the Government of India may be adopted by the states and they may plan and implement Urban Health programmes as per the applicable guidelines to the extent possible, with local adaptations, as may be required, with due justifications. Dissemination of 'Sample Urban Slum Health Proposals', commissioned by Government of India through the means mentioned above, as also other means, as considered appropriate could help states in developing their own city specific Urban Health Projects.

## **4.0 Institutional Mechanisms at different levels**

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### **4.1 National Level**

At the national level, there may be a National Urban Health Mission similar to National Rural Health Mission, aimed at doing the needful for providing essential and quality health care to the urban population all through the country, especially for the people from poor and slum sections. Like in NRHM, National Urban Health Mission will provide a special focus to 18 NRHM high focus states, which have weak public health indicators and/or weak infrastructure.

Mission Steering Group (MSG) constituted for NRHM under the Chairmanship of Union Minister of Health & Family Welfare may provide the policy guidance and operational oversight at the National Level with addition/inclusion of some more members concerned with urban areas and Urban Health viz. ministerial/secretarial level representatives of Ministries of Urban Development, Urban Employment & Poverty Alleviation, and five Urban Health Experts (on biennial rotational basis). The Mission Director of proposed NUHM may also be made a member, in fact as, yet another Co-convenor of the proposed expanded MSG, with exclusive job responsibilities directed at Urban Health.

The functional mandate of the MSG would have to be suitably amended, if necessary, to enable it to have under its ambit/domain issues relating to Urban Health as well, with the proviso that, whenever it meets, the MSG shall take up Rural Health and Urban Health related issues as distinct/stand alone entities, so that, along with Rural Health, Urban Health also receives the due and required attention of the MSG. This could be accomplished, for instance, by having separate agenda points and agenda documents for rural health and urban health to be considered for decisions and directions by the MSG.

Similarly, Empowered Programme Committee (EPC) constituted under NRHM under the chairmanship of Union Secretary of Health & Family Welfare may be expanded in terms of its composition through the addition of some more members viz. Secretary level representatives from the Union Ministries of Urban Development, Urban Employment and Poverty Alleviation, Mission Director of proposed NUHM (as Co-convenor) and two Urban Health experts (on biennial rotational basis), and in terms of functional mandate, if required, by bringing under it the entire gamut of issues pertaining to Urban Health.

The EPC may be assisted by an Urban Health Mission Directorate at National Level. It may also be ensured through appropriate/enabling provisions that, whenever EPC meets for discharging its mandated functions, it will pay due attention to rural health and urban health issues as distinct/standalone entities, so that, along with Rural Health, Urban Health also receives the due and warranted attention of the EPC. This could be accomplished, for instance, by having separate agenda points and agenda documents for Rural Health and Urban Health to be considered for decisions and directions by the EPC.

The above suggestion for distinct treatment of these two entities viz. rural health and urban health has been made especially in view of the fact that, in terms of conscious governmental planning, efforts and investments, urban health lags its rural counterpart by several decades and desperately requires at this stage a strong patronage and backup from the Government to be able to take off expeditiously and get installed/stabilized at the earliest possible.

#### **4.1.1 National Urban Health Mission Directorate**

The Mission Directorate for Urban Health would be the highest body to look after the operational aspects of all the issues pertaining to Urban Health under National Urban Health Mission. The Mission Directorate for Urban Health will play a pivotal role to provide directives, monitor and issue guidelines for improving the provisioning of effective healthcare for urban poor population through out the country.

The Mission Directorate may be established in the Ministry of Health & Family Welfare, Government of India and be headed by a **Mission Director** who is of the level of Additional Secretary to Government of India. Under the Mission Directorate, there may be five Joint Secretary level officers of the Government of India as members, whose roles and responsibilities need to be clearly defined.

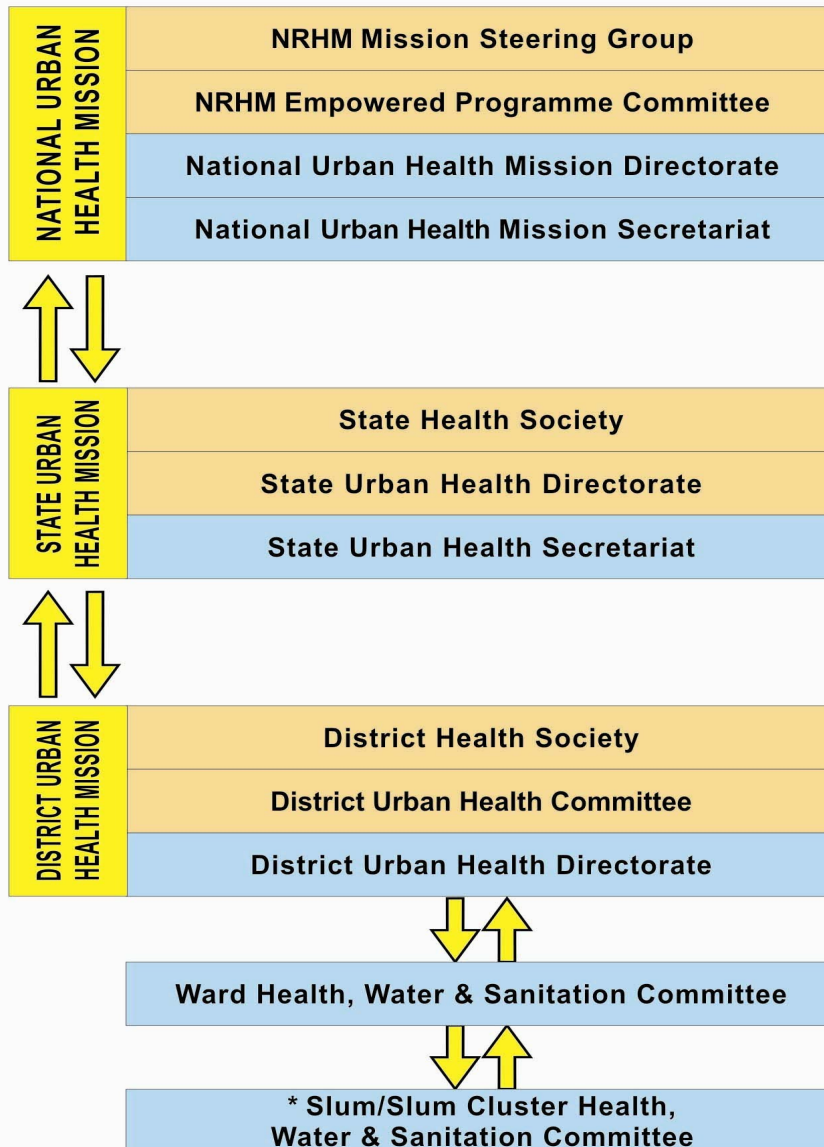
#### **4.1.2 National Urban Health Mission Secretariat**


The Mission Secretariat may have a Director or above level officer as In-charge. Additionally, it may have 1-2 UH Consultants, with required secretarial staff.

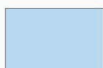
The role of the National Urban Health Mission Secretariat could *inter-alia* be to:

- Carry out all the directives of Mission Directorate
- Support the states in planning and implementation of urban health Programmes
- Monitor the sanctioned Urban Health programs in States and oversee the progress of the projects; provide feedback to the states and make suggestions for Programme improvement
- Attend review meetings on the progress of the projects, including fund utilization
- Examine the UH component of state PIPs/Urban Slum Health proposals received from the states and provide inputs to improve them, wherever found necessary.
- Facilitate the process of releasing of funds timely and appropriate submission of prescribed/required documents by the implementing states such as Statement of Expenses, Utilization Certificates and Audited Statements
- Coordinate national level capacity building workshops or training Programmes on Urban Health for states
- Liaise and coordinate with various specialized agencies in urban health matters; support national and regional meetings to bring together various UH experiences and learnings
- Support the development of urban health related documents and dissemination to state governments and other agencies
- Help states in establishing an Urban Health Technical Resource Center at an appropriate site and support capacity building and other activities of the states
- Support coordination between MOHFW and the UH Resource Unit at NIHF and ensure adequate incorporation of UH component in RCH training Programme

Diagram depicting Institutional framework for proposed National UH Mission



 Primarily Policy, Review and Direction functions

 Primarily Planning, Project Formulation, Implementation, Monitoring and Feed back functions

\* Because of heterogeneity in the ward size (population) in the country, states could consider to constitute 'Slum' or 'Slum Cluster' level committees, in place of 'Ward Committee', which are equivalent to Village Level Health Committee under NRHM.

## **4.2 State Level**

At state level, the State Health Mission constituted under NRHM (Chaired by the Chief Minister, Co-chaired by Health & Family Welfare Minister and convened by the State Health & Family Welfare Secretary) may be suitably expanded to include proposed State Urban Health Mission Director as a member, and also provide for representation from Urban Health and related departments, NGOs and few Urban Health experts etc. However, wherever the situation warrants, the States could make modifications in this regard appropriate to their context.

### **4.2.1 State Health Society**

The State Health Society is responsible for planning and managing all health & family welfare programmes in the state, both in the rural and urban areas. The Task Force recommends inclusion of some members from State Urban Development/Municipal Affairs Department, Mayors/Municipal Commissioners from two to five cities of state on rotational basis (depending upon the size of the state), State Urban Health Mission Director and some experts from Urban Health field in the State Health Society.

It may also be ensured through appropriate/enabling provisions that, whenever State Health Society meets for discharging its mandated functions, it will pay due attention to rural health and urban health issues as distinct/standalone entities, so that, along with Rural Health, Urban Health also receives the due and warranted attention of this Society. This could be accomplished, for instance, by having separate agenda points and agenda documents for Rural Health and Urban Health to be considered for decisions and directions by this Society.

### **4.2.2 State Urban Health Mission Directorate**

On the lines of its National Level counterpart, a similar UH Mission Directorate is suggested at the State Level. Its Mission Directorate could be headed by an officer, at least of Commissioner/Secretary Rank. The State Mission Directorate on Urban Health could be responsible *inter-alia* to

- Suggest coordination mechanisms among various stakeholders.
- Provide guidance to State UH Mission Secretariat in developing UH proposals and incorporating them into State PIP
- Approve Urban Health proposals of State
- Be accountable for proper and effective utilization of funds allocated for Urban Health related activities as well as mobilize additional resources for UH within the NUHM or from other concerned departments/organizations
- Urban Health Advocacy

### **4.2.3 State UH Mission Secretariat**

The State UH Secretariat may be headed by a Director level official and assisted by some UH consultant/s and secretarial staff.

The role of the State Urban Health Secretariat may *inter-alia* be to

- Carry out the directives of State Health Society and State Urban Health Directorate.
- Support development of Urban Health proposals of the districts and incorporate them into the State Programme Implementation Plan (SPIP)
- Issue operational directions based on review at the district level and instructions/guidance provided by the State UH Mission Directorate for speeding the process of proposal development
- Coordinate with National UH Mission Directorate

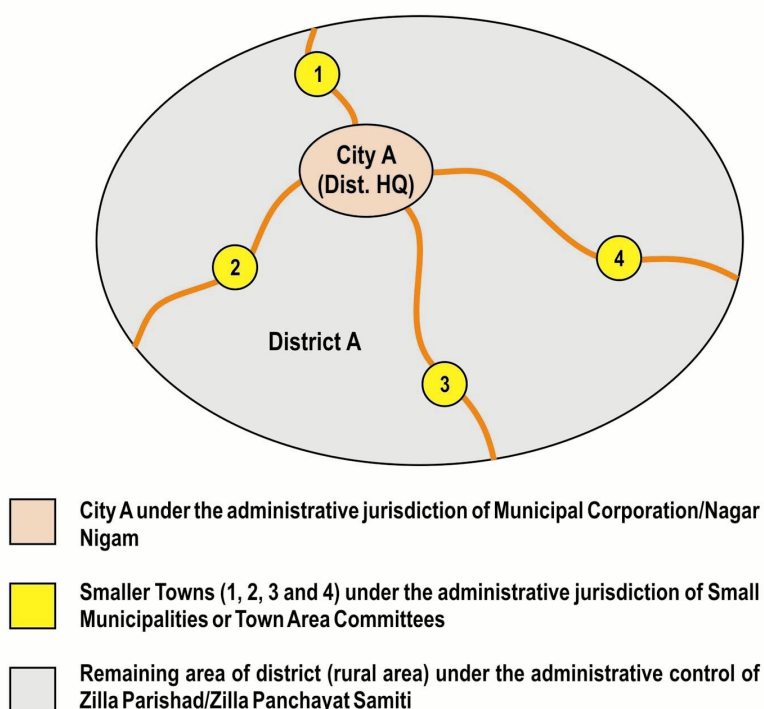
- Coordinate with rural counterpart of State Health Mission as per the need
- Submit UH proposals to State Health Society for approval and its follow-up with Government of India
- Ensure timely release of funds from the State Health Society and its distribution to districts; submission of statement of expenditure, utilization certificates and audited statements of District Programmes
- Facilitate the Districts to fulfill review and monitoring requirements as determined by State Health Society, based on GOI guidelines for UH Mission.
- Support districts in implementation of UH Programmes; follow-up with district officials and District Urban Health Mission to pursue and coordinate support as required for planning and implementation of UH Projects.
- Coordinate monitoring and review visits to districts
- Information sharing through making UH data, information, experiences and studies available for state & district officials, ULBs, NGOs, Research Organizations and others
- Organize Urban Health Capacity Building/Enhancement Workshops & consultations on important issues having a bearing on the implementation of UH Programme like PPP.
- Capacity building of district officials through identifying and coordinating with technical resource agencies for Training and Capacity Building
- Provide support to districts for PPP by issuing Model TORs/screening criteria/developing monitoring and reviewing mechanisms
- Facilitate issuance of directives/circulars and operational guidelines for achieving effective coordination of health department vis-à-vis SUDA/DUDA, ICDS etc.
- Advocacy with the departments for updating of slum lists based on the situation analysis for developing UH proposals

### **4.3 District Level**

To support the District Health Mission, every district has an integrated District Health Society (DHS). The District Health Society shall be responsible for planning and managing all health & family welfare programmes in the district, covering both, the rural and urban areas. At District level, the over all policy directives and guidance to Urban Health Mission shall be given by District Health Society.

Under *Panchayati Raj*, in the districts, all the rural areas come under the jurisdiction of the *Zilla Parishad* or *Zilla Panchayat*. The urban areas come under Urban Local Bodies. The bigger towns have Municipal Corporations and smaller towns have Town Area Committees or Municipalities. The following diagram shows various administrative institutions in a typical district:

Diagrammatic representation of administrative control of various Panchayati Raj Institutions in a classical district (District A)



#### 4.3.1 District Health Society

The model suggested for the District Health Society under NRHM has 3 distinct bodies – (a) Governing Body, (b) Executive Committee and (c) District Programme Management Support Unit for carrying out various functions.

'Mayor' or 'Chairperson – Municipal Corporation' can be made 'Co-Chair'; and Municipal Commissioner as 'Co-Convenor' of the Governing Body of District Health Society. The DHS shall have some members like - Chairpersons of other smaller Municipalities/Town Area Committees in the district, Project Officer – DUDA and Municipal Health Officer/*Nagar Swasthya Adhikari*.

Similarly, for Executive Committee of District Health Society, Municipal Commissioner shall be made 'Co-Chair' and Project Officer DUDA and Municipal Health Officer/*Nagar Swasthya Adhikari* as 'members'.

#### 4.3.2 District Urban Health Committee

Operationally, the District Urban Health Mission may function under District Urban Health Committee. The management capabilities of Urban Local Bodies vary from state to state. Based on their management capabilities the following institutional arrangement are proposed for different type of cities :

(A) **Mega cities**, where the Urban Local Bodies are generally large and strong, following is the suggested list of Members of (District level) Urban Health Committee:

1. Mayor - **Chairperson**
2. Municipal Commissioner – **Co-Chairperson**

3. MP, MLA and MLCs from the City
4. Chairpersons of District Hospital Management Society/Rogi Kalyan Samiti
5. Project Officer – DUDA or Equivalent
6. District Programme Managers for Health, Immunization, PHED/Jal Nigam/Jal Sansthan/Water Supply and Sewerage Board, ICDS, Education, Social Welfare etc
7. Nominated non-official members such as health experts, representatives of professional medical associations like IMA/IAP/FOGSI and NGO & RWA representatives
8. District Level Officers of donor supported projects viz. World Bank, WHO, UNICEF, DFID, USAID, UNFPA etc.
9. Medical Superintendent/s of District Hospitals and District Women’s Hospitals
10. Chief Municipal Health Officer or Equivalent– **Member Secretary**

(B) **Medium to small cities** with strong ULBs, following is the suggested list of Members of District Urban Health Committee:

1. Mayor - **Chairperson**
2. District Magistrate– **Co-chairperson**
3. Municipal Commissioner
4. MP and MLA representing urban constituencies of the district
5. Chairpersons of District Hospital Management Society/Rogi Kalyan Samiti
6. Chief Medical Officer/District Health Officer/Civil Surgeon
7. Project Officer – DUDA or Equivalent
8. District Programme Managers for Health, Immunization, PHED/Jal Nigam/Jal Sansthan/Water Supply and Sewerage Board, ICDS, Education, Social Welfare etc
9. Nominated non-official members such as public health experts, representatives of professional medical associations like IMA/IAP/FOGSI and NGO & RWA representatives
10. District Level Officers of donor supported projects viz. World Bank, WHO, UNICEF, DFID, USAID, UNFPA etc.
11. Chief Medical Superintendent/s of District Hospital and District Women’s Hospital
12. Chief Municipal Health Officer/Nagar Swasthya Adhikari<sup>17</sup> or Equivalent – **Member Secretary**

(C) **Medium to small cities** with weak ULBs (e.g. UP), following is the suggested list of Members of District Urban Health Committee:

1. District Magistrate– **Chairperson**
2. Mayor- **Co-chairperson**
3. Chairman Zilla Parishad/Zilla Panchayat Samiti
4. Municipal Commissioner
5. MP and MLA representing urban constituencies of the district
6. Chairpersons of District Hospital Management Society /Rogi Kalyan Samiti
7. Municipal Health Officer/Nagar Swasthya Adhikari
8. Project Officer – DUDA or Equivalent
9. District Programme Managers for Health, Immunization, PHED/Jal Nigam/Jal Sansthan/Water Supply and Sewerage Board, ICDS, Education, Social Welfare etc
10. Nominated non-official members such as health experts, representatives of professional medical associations like IMA/IAP/FOGSI and NGO & RWA representatives
11. District Level Officers of donor supported projects viz. World Bank, WHO, UNICEF, DFID, USAID, UNFPA etc.
12. Chief Medical Superintendent/s of District Hospital and District Women’s Hospital

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<sup>17</sup>representative of Municipal Health Officers where there is more than one municipality in a district could be nominated by the Chairperson of committee.

### 13. Chief Medical Officer or Equivalent – **Member Secretary**

Apart from providing overall oversight and carrying out the directives of State Urban Health Mission, the District Urban Health Committee may also:

- Suggest various coordination mechanisms among various stakeholders
- Appraise and forward Urban Health proposals of the District
- Mobilize additional resources for UH within the NUHM or from other possible department/organizations
- Urban Health Advocacy

The District Urban Health Committee shall also provide support and legitimacy to the field level coordination unit at the Urban Health Centre level.

#### **4.3.3 District Urban Health Directorate**

On the lines of national and state levels, the districts may also have a District Urban Health Mission Directorate to issue directives of District Urban Health Mission to Mission Secretariat. This Directorate may be headed by a full time Mission Director. The efficient functioning of this Directorate could be supported by a District Urban Health Secretariat, which can either be a separate unit or a part of existing District Programme Management Support Unit (DPMSU). Wherever Urban Health Cells already exist or else, as and when such cells get established, they can discharge the functions of such a Secretariat. In order to ensure efficient functioning of this Secretariat, the Mission Director may nominate a Deputy CMO/Municipal Health Officer, (as the case may be), level or equivalent officer or a suitable incumbent for this position on contractual terms. S/He shall be supported by finance and secretarial staff.

The responsibilities of District UH Secretariat may include:

- Implementing the directives of District Health Society/District UH Directorate.
- Monitoring the program at District level on monthly basis and report the progress to State UH Secretariat.
- Issuing minutes of meetings.
- Documentation of programme innovations and best practices
- Organizing capacity building of district/municipal officials through support of State Urban Health Secretariat.
- Ensuring availability of state level circulars and directives to other departments.
- Guiding small municipalities/Town Area Committee officials to develop their own UH programmes and help them in fixing their priorities.
- Monitoring private/trust hospitals in the city limits if they are extending 10% of their bed strength to urban poor<sup>18</sup>.

**Note:** Districts having more than one city can consider formulating City/Municipal Level Coordination Committee.

#### **4.4 Sub-district Level**

##### **4.4.1 Ward/Slum/Slum Cluster Level Health, Water and Sanitation Committee**

At sub-district level, 'Ward' may be the basic unit for planning and monitoring. Because of heterogeneity in the ward size (population) in the country, states could consider to constitute 'Slum' or 'Slum Cluster' Level Committees, in place of 'Ward Committee'.

The Ward Health, Water and Sanitation Committee under the stewardship of Ward Councilor will provide direction to the integrated efforts to health, water supply and

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<sup>18</sup>

<sup>1</sup> Especially when the land for the hospitals is provided at subsidised rates by the governmental or parastatal agencies

sanitation. In this, the catchment areas for ANMs should be planned in such a way that it is co-terminus with ward boundaries as far as possible.

The following shall be the responsibilities of Ward Health, Water and Sanitation Committee

- Monitor the programme of Ward on monthly basis, and provide progress to District UH Secretariat
- Review of quality of work at the UHC and community linkages
- Provide solutions to problems at the UHC level by coordinating with the city officials
- Carry out the health and sanitation assessment of the area which can be put up as proposals to DUDA through District UH Secretariat under various schemes
- Take up pertinent coordination/collaboration issues having a bearing on the health of the communities living in the area
- Delegation of the responsibilities to concerned group member for adequate response to the identified need.

*Note: Since the population in a ward is usually large, a Slum/Slum Cluster Committee on the lines of Ward Health, Water and Sanitation Committee could be set up concurrently for the planning and monitoring purposes at the Slum or Slum Cluster level.*

#### **4.4.2 Suggested members of Ward Level Health, Water & Sanitation Committee:**

1. Ward Councilor - **Chairperson**
2. Public Health Nurse & ANMs
3. Supervisor – ICDS and Anganwadi Workers
4. Education Department Representative
5. Sanitary Inspector/Member from Water Supply and Sanitation Department/PHED
6. CDS Representative – DUDA
7. NGO Representative/Charitable Institutions Representative
8. Representative from Link Volunteer/ Women’s Health Committee/Cooperatives
9. Lady Medical Officer I/C UHC – **Member Secretary**

#### **4.5 Inter-sectoral coordination mechanisms**

The Task Force recommends the following mechanisms for inter-sectoral coordination towards improvement of health status in slums:

- Convergence between Jawaharlal Nehru National Urban Renewal Mission (JNNURM) and National Urban Health Mission in select cities at City level; similarly, convergence between the Integrated Housing and Slum Development Programme (IHSDP) covering cities and towns not covered under JNNURM and National Urban Health Mission in the cities covered under IHSDP.
- Convergence between the elected body and city administration within National Urban Health Mission.
- Convergence between Department of Women & Child Development and DoHFW on use of field level workers (AWWs and Link Volunteers), prioritizing the setting up of Anganwadi Centres in vulnerable slums, developing MCH/RCH and adolescent health programmes jointly.
- Level of convergence of activities between NACO/State AIDS Control Society and National UH Mission is left at the discretion of the state; however, the State AIDS Control Society should be actively involved in the UH Planning activity at the state level.

- Convergence in the field should be explored and exploited with agencies responsible for promoting Community Based Organizations (CBOs) in slums.
- Convergence with development partners such as USAID, UNICEF, UNFPA, DFID, ADB, World Bank in areas where they are already engaged actively or are planning activities concerning slum improvement.
- Health education and adolescent discussion forums should be developed as part of the school health programme through convergence with the Education Department.

#### **4.5.1 UHC/Ward level Coordination Forum**

A UHC level Coordination Forum may be constituted to facilitate all the activities pertaining to catchment area of the particular Urban Health Centre. The forum shall be headed by the Ward Councilor with Lady Medical Officer In-charge Urban Health Centre as convener. The other members are from the department of Health, Slum Development, ICDS, Education, Water & Sanitation, and NGO representative. The Committee shall meet once every month to resolve all issues creating obstruction in smooth implementation of UH activities planned for the Slum Cluster/Ward.

#### **4.5.2 District Level Coordination Forum**

At district level, the District Health Society may coordinate with various stakeholders and facilitate the smooth implementation of Urban Health Programme in the district.

#### **4.5.3 State Level Coordination Forum**

At state level, the State Health Society may coordinate with all the concerned departments and ministries and solve the issues obstructing the implementation of effective urban health programme in the state.

#### **4.6 Rogi Kalyan Samitis/Patient Welfare Committees**

Rogi Kalyan Samiti is a registered society which acts as a group of trustees for the hospital/health facility to manage the affairs of the hospital/health facility. It consists of members from local PRIs, ULBs, NGOs, local elected representatives and officials from government sector, who are responsible for proper functioning and management of the hospitals, CHCs and PHCs. RKS is free to prescribe, generate and use the funds available with it as per its judgment for the smooth functioning and maintaining the quality of services.

The Task Force recommends constitution of *Rogi Kalyan Samitis/equivalent institutions* at UHC and Zonal Hospital level on lines similar to that of NRHM, in order to ensure accountability of the public sector health providers to the community, improved quality of health services, introduce financial transparency and raise additional funds for meeting various requirements.

### **5.0 Role of Urban Local Bodies**

The 74<sup>th</sup> Constitutional Amendment Act has transferred the management of health care facilities in urban areas to the Urban Local (Municipal) Bodies almost a decade back. However, the capacity of the Urban Local Bodies (ULBs) to lead, plan and manage UH Programme is not only limited in most cases, but also varies from state to state;

therefore the Task Force recommends that, depending upon the levels of involvement of the ULBs in the health related activities as also on the extent of decentralization, differential strategies be adopted on the lines mentioned below:

In the states where traditionally and over the years, the urban local bodies (ULBs) have been playing a substantial and significant role in provisioning of health care services, the Task Force recommends that the 'Mayor' or 'Chairperson' – Municipal Corporation can be made 'Co-Chair'; and Municipal Commissioner as 'Co-Convenor' of the Governing Body of District Health Society. The District Health Society may include few more members viz. Chairpersons of other smaller Municipalities/Town Area Committees in District, Project Officer District Urban Development Agency (DUDA) and Municipal Health Officer/*Nagar Swasthya Adhikari* to its Governing Body. Similarly, it may also include Municipal Commissioner and Project Officer, DUDA and Municipal Health Officer/*Nagar Swasthya Adhikari* to the Executive Committee of District Health Society.

The primary UH infrastructure in the city be managed by the Urban Local Body, keeping the 'Ward' as the basic unit of planning and implementation. In the case of such states, the Task Force further recommends that the 'Slum' or 'Slum Cluster' Level Health, Water & Sanitation Committee (similar to the role envisaged for Village Health Committee in NRHM) be vested with the responsibility to guide all UH activities at the slum level. This committee will be responsible for developing the slum health plan, with the support of ANM, Link Volunteer, AWW (wherever present) and slum level community organizations (like *Basti Sudhar Samiti*). In the case of states in this category, the Task Force further recommends the strengthening of the health department/wing of the Municipality inter alia by devolution of funds and strengthening of Human Resources.

In the other states where traditionally and over the years, the urban local bodies (ULBs) have not been playing a substantial and significant role in provisioning of health care services the states should take the lead in planning and implementing urban health programme and concurrently also take appropriate steps to gradually phase out the responsibility of managing UH infrastructure to ULBs.

In the case of States (for example West Bengal) and in Metropolitan cities, where the ULBs have been able to implement Urban Health Programme satisfactorily in the past, under an already functional institutional arrangement, the concerned states if they so feel, may choose to continue with existing arrangements.

In case of other States where the ULBs are still to develop into entities strong enough to efficiently manage the Urban Health Program/activities in their jurisdiction, even while doing all it takes to enhance their professional and management (including financial) capacities to the required levels, till such time that happens, the Municipal Health Officer (or equivalent) and one or two elected representatives associated with the Health function of the ULB may be included as integral constituents viz. members of the District Urban Health Committee. The functioning of this committee may, in the interim, be coordinated by a Deputy CMO level official of the Health Dept. with the District Magistrate as its Chairperson. As quickly as possible, and in a sustainable manner, in the medium/long term, the responsibility for formulating and implementing Urban Health Program may be handed over to the ULB in line with the provisions of the 74<sup>th</sup> Constitutional amendment.

Capacity building of the ward councilors in the areas of planning and management of UH care delivery services needs due attention to be paid. In these states, efforts should also be made to involve the 'Slum' or 'Slum Cluster' Level Health & Sanitation Committee in

planning and guiding all UH activities at the slum level with the support of ANM, Link volunteer, AWW (wherever present) and slum level community organizations (like *Basti Sudhar Samiti*).

## **6.0 Public-Private Partnerships (PPP)**

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Recognizing that government health facilities do not have adequate reach in urban slums leading to low demand and poor utilization, contracting the delivery of health services to the private sector has emerged as a viable option. Many state governments have experimented with this approach with different levels of success. Some state governments have also contracted private hospitals to provide outreach activities (using the private partner's facilities and staff) in un-served areas and also provide referral support.

There is a considerable existing capacity among private providers (NGOs, medical practitioners and other agencies), which should be explored, fruitfully exploited and operationalised. Such partnerships are particularly likely to be viable in urban areas. Focusing on activities that can yield quick, encouraging and sustainable results is required, so that the overall objective of Urban Health Programme could be successfully achieved.

Potential private partners for both the tiers should be identified and tapped optimally to improve the quality and standard of health among the urban poor, by capitalizing on the skills of potential partners, encouraging pooling of resources, and supplementing the investment burden on the Government of India's resource deployed in the health sector.

Looking at experiences of various models tried in several states of our country, the following scenarios evolve where a successful PPP could be tried depending on the situation obtaining in a given location/city.

- A. In cities or parts of a city where first tier public sector health infrastructure (by way of Health Posts or UFWCs) is already available, a partnership with NGOs could be considered for enhancing utilization of these existing Public Sector services through identification and training Link Volunteers, women's groups, social mobilization and supporting IEC/BCC activities ; and
- B. In cities or parts of a city where no public sector first tier facility is available, the entire first tier service delivery component may be contracted out through partnership with a charitable hospital or an NGO or any appropriate private agency with requisite capacity.
- C. Private medical practitioners could also be engaged on part-time basis for first as well as second tier facilities (based on the experience in IPP VIII in Kolkata and neighboring cities).
- D. 2<sup>nd</sup> tier services (including laparoscopic tubal ligation and no-scalpel vasectomy services) and diagnostic services may be outsourced to private medical facility on reimbursement basis. A uniform rate list needs to be enforced for such services. Wherever worthwhile and feasible, second tier services can also be contracted out to charitable hospitals, with proven credentials.

Appropriate mechanisms for partnering (or entering into agreement) with the private sector needs to be considered, including accreditation methods (for ensuring quality), memorandum of understanding, reporting and monitoring systems etc.

Urban areas are much better placed for exploring and exploiting PPP, with several stakeholders already having a hold in the cities. However, there needs to be appropriate systems in place before attempting scaling it up.

The Task Group on PPPs under NRHM has suggested certain broad regulating mechanisms for PPP, however for urban areas, some specific requirements for evolving appropriate PPPs at the state and district levels were identified by the task group such as:

- Guidelines on 'How-to' develop partnerships and capacity building on this.
- Sample ToR and MoU
- Screening criteria to be formulated for the selection of appropriate partners
- Protocols needed for enabling and ensuring proper quality of care at the facility
- Financial mechanisms and fund flow

The partnerships should be developed through consultations and dialogue with concerned stakeholders, and a workshop could be organized to obtain an idea about different perspectives and different possible approaches that could be adopted. It was also suggested that MOHFW, GoI should document and disseminate experiences and best practices of PPP for slum health, and some ongoing models were also suggested for this purpose.

Some possible areas of partnerships that could be planned within UH Programmes were identified as:

- Providing primary health care services – management of 1<sup>st</sup> tier health facilities
- Provision of 24 hour maternity services
- Sterilization services on regular/routine basis and mobilization of male partners
- Diagnostics
- Identification, training and management of Link Volunteers for demand generation and BCC
- Referral transport facility
- Contracting out of specific vulnerable areas for all services
- Independent evaluations
- Mapping of slums and facilities and Situational Analysis of the city

Possible partners in urban areas could be

- Professional associations (e.g. IMA, IAP, FOGSI etc.)
- NGOs and Charitable Organizations
- CBOs and other community level groups such as Self Help Groups etc.
- Charitable Hospitals
- Health practitioners and Nursing Homes
- Medical Colleges
- Corporate sector

It is also suggested that the not-for-profit sector may be encouraged for partnerships, in addition to the profit oriented/profit motivated private sector.

## **7.0 Monitoring and Evaluation Plan**

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It is generally a well recognized fact that there is a lot of scope and infact /indeed a lot of necessity for effecting substantial improvements in the system of production, analysis and dissemination of health statistics, especially in view of the critical role which they are expected to play with regard to "Monitoring and Evaluation" of the various health sector policies and programmes initiated and implemented. This issue acquires an even more special significance in the context of RCH II programme (under the National Rural Health Mission) which relies rather heavily upon the principle of result based management. While the task of production of qualitatively good and timely dissemination of health data

and indicators based thereon cannot be over emphasized, what is equally important, if not more, is to have some appropriate mechanisms and systems in place in terms of "statistical audit" in this regard. In other words, it is imperative to take a close look at and keep a continuous and close watch on the systems/ systemic arrangements which have been put in place for production of health statistics and also ensure that necessary validation systems/ procedures exist and operate, as required so that the scope is minimized for even unconsciously arriving at incorrect conclusions / inferences based on erroneous data or else data which are statistically suspect. This aspect has also become much more important now than ever before as the country has already entered an era of outcome/output based budgeting and reporting.

Community Level/based Monitoring is recommended at slum level. Under NRHM, there are already institutional mechanisms proposed to supervise and monitor mission work at various levels. The same monitoring mechanisms can be utilized effectively for National UH Mission also. Just as it is very important to ensure the participation of the concerned community (besides other stakeholders) at the stages of planning and programme implementation it is equally, in fact vitally important to ensure the involvement of the community in regular, periodic monitoring and evaluation exercises to be undertaken to assess/ gauge the progress, at any given point of time, with regard to already launched urban health initiatives. In the larger interest of the efficacy of the urban health programmes and ensuring that the envisaged benefits accrued to the target population, it is also recommended that suitable provisions be created whereby the ongoing urban health programmes will also be subjected to evaluation by certain independent/ external agencies with proven credentials for undertaking such evaluation exercises.

The M&E plan should include an appropriate process for benchmarking, development of urban HMIS consistent with the national MIS, mechanism for monitoring of key processes and results, pertaining to promotion of Family Planning and Maternal & Child Health services, and periodic assessments of field activities, and also end-line evaluation.

Suitable mechanisms and appropriate systemic arrangements have to be evolved, put in place and implemented for periodic updation (by an appropriate agency already existing or else to be created within the government system) of data/details concerning health and related aspects of urban areas.

At first tier facility monthly monitoring of key processes and outcomes by the District UH Secretariat/DPMSU is recommended. District UH Secretariat shall send its report to State UH Secretariat on monthly basis, which in turn shall compile it and send it to Government of India every quarter.

Broad monitoring in line of NRHM and more intense monitoring for 18 NRHM-High focus states by Government of India level is recommended to give the required impetus and push/back-up to UH activities.

State Urban Health Mission should plan and coordinate baseline survey (which can be outsourced to a suitable agency, if necessary) in identified cities. A total of 3 evaluations are to be conducted – (1) baseline, (2) midterm/concurrent and (3) end term surveys depending on the actual need in the state.

The baseline indicators may be estimated by using the data already available from District Health Survey/reports, other available reports and sources of data. Benchmarking should specially focus on contraceptive usage, terminal methods adoption, immunization coverage, TT coverage, delivery care and infant care. In-depth 6-monthly reviews and a mid-term rapid assessment are also proposed to ensure timely achievement of results and make mid-course corrections as required.

## 8.0 Sustainability

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Mechanisms for cost recovery may be built as an integral part into the proposal. However, this should be based on the principle of inclusion of the poorest. The experiences of the Kolkata IPP VIII project in cost recovery may be drawn upon. Under IPP VIII, Kolkata, there was a system/practice of levying differential user charges on services provided, which was put in a corpus fund and was utilized for sustaining the Project activities after the project period. Such a corpus Urban Health Fund at the city level is desirable to be steadily built to partially sustain the recurrent costs after project completion. Such a fund can be built through several sources of contribution which *inter-alia* include: portion of user charges (from middle class and upper class families) from diagnostic services, surgeries etc. at second tier, registration fees/family health card charges from all families collected at first tier and during outreach camps, donations from business houses, individuals, banks etc., appropriation received from National Slum Development Programme of GOI (ULB can access 5 times the amount generated at local level by communities from NSDP), and portion of lease and rental income from Municipal or other Public sector buildings.

A mechanism for periodically monitoring progress of such a corpus fund should be put in place. In addition to the corpus health fund, a) institutional capacity at community level, through federation of community groups for linkage with *Integrated Housing & Slum Development Programme* [sponsored by Ministry of Urban Employment & Poverty Alleviation, GOI] earlier called as *Swarna Jayanti Shahari Rozgar Yojna* and CDS Scheme, and b) enhancing the capacity of the Urban Local Body to plan and manage such programmes are some possible approaches towards sustainability.

While on the issue of sustainability it would be also important to ensure that all the committees, groups, institutional mechanisms created, as part of Urban Health endeavours, are sustained as viable entities even beyond the currently sanctioned tenure of proposed NUHM, by deploying appropriate methods.

<b>Box -1: Estimation of Budget for Urban Health</b>	
Urban Population (2001 Census)	286,119,689
Urban Growth (Decadal Growth Rate 1991-2001)	31.79
Estimate current Urban Population (2006)	331,526,884
Estimated population of towns having population less then or equal to 100,000 (2001)	110,661,560
Target population for the Urban Health programme	220,865,324
Number of Primary Level Health Facilities existing*	1,197
Number of primary level health facilities as per the norm (1 per 50,000 Population)	4,417
Number of primary level health (UHCs) facilities required	3,220
Funds required for <u>one</u> Urban Health Centre (on <u>NEW CONSTRUCTION BASIS</u> ) for 5 Years	12,505,400
Funds required for <u>one</u> Urban Health Centre (on <u>RENTAL BASIS</u> ) for 5 Years	10,635,400
Total funds for UHCs (20% of total required UHCs) - NEW CONSTRUCTION BASIS	8,053,477,600
Total funds for UHCs (80% of total required UHCs) - RENTAL BASIS	27,396,790,400
<b>Total fund required for Primary Level Facilities (UHCs)</b>	<b>35,450,268,000</b>
Number of First Referral Level Health Facilities (except District Hospitals) existing**	Data NA
Number of First Referral Level Health Facilities (Zonal Hospitals) as per the norm/required (1 per 250,000 Population)***	883
Funds required for <u>one</u> Zonal Hospital for 5 Years	44,960,920
<b>Total Funds required for First Referral Level Facilities (Zonal Hospitals)</b>	<b>39,700,492,360</b>
Funds required for the management of <u>one</u> NGO at Zonal Level for 5 Years	12,925,250
<b>Total funds required for NGOs management</b>	<b>11,412,995,750</b>
<b>Total funds required</b>	<b>86,563,756,110</b>
Funds for UH Planning and Situational Analysis @ Rs 1,000,000 per district for 604 Districts	604,000,000
Management Cost at all levels @ 6%	5,193,825,367
Capacity Building @ 0.5%	432,818,781
Research, documentation & dissemination @ 0.25%	216,409,390
<b>GRAND TOTAL</b>	<b>93,010,809,647</b>

\*This number excludes the facilities owned by ULBs. \*\*Details of number of actual second tier health care facilities are not known since data is not available. District Hospitals are not included while making the calculation. \*\*\*The requirement estimated does not include District Hospital, which is primarily meant for the whole district of approximately 2 million Population.

## 9.0 Funds for Urban Health Programme

An estimated allocation of approximately Rs. 3250 crores in the first year and Rs. 6051 crores in next 4 years (a total of 9301 crores for 5 years) from the Centre to the States may be required to enable adequate focus on urban health (refer to *Box-1 and Appendix - 1* for the basis of computation of these figures). This budget includes allocation towards (a) programme management cost, (b) planning and conducting situational analysis, (c) capacity building activities and (d) research, documentation and dissemination. The allocation may be reviewed subsequently mid-course and appropriate adjustments made if and when required. As mentioned earlier, the above mentioned fund is meant to cover only all the cities/towns having a population of 1,00,000 or more.

As per Census 2001, about 110.66 million people live in towns having less than 100,000 population. The state Governments have been advised to go in for exclusive/dedicated UH projects for only those identified and prioritized urban areas having a population of more than 100,000. Hence, with a view to ensuring that the aforesaid large chunk of urban population does not get left out inadvertently, the Task Force recommends provisioning of health care services to this population through the rural health component of NRHM.

The proposed Urban Health Mission budget is meant to complement the already created/existing Urban Health infrastructure and to improve efficacy of schemes of Government of India such as Janani Suraksha Yojna and Immunization where provisions are already available for rural and urban areas. Also, these budget estimates do not provide allocations for various disease specific National Health Programmes such as RNTCP, NLEP, NACP, National Programme for Control of Blindness, National Anti Malaria Programme, Iodine Deficiency Disorder Control Programme *etc.* for which budgetary provisions have been already kept under NRHM for both rural and urban areas.

For keeping clear accountability and transparency; and to facilitate tracking of program progress from time to time, it is recommended to maintain independent, clearly specified budget lines and separate book of accounts for rural health and urban health at State and District Health Society level

In view of the fact that serious government initiatives are still at an embryonic stage in so far as UH is concerned, the Task Force opines that it would be most probably required and worthwhile for GOI to consider extending the requisite policy and financial support to the structures created and mechanisms instituted in urban areas during the tenure of the proposed NUHM, even beyond its tenure.

## **10.0 Operationalization of Urban Health Programme**

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Since adequate capacity at the state and district/city level does not exist at present for planning and implementing the urban health component, the Task Force recommends that urban health programme be implemented in phased manner during the tenure of the proposed National Urban Health Mission spanning the period of five years.

The Task Force recommends that, to start with, only the cities with substantial urban population be taken up by the states for Urban Health project formulation and implementation.

### **10.1 Suggested steps at the national level**

- Comprehensive and clear cut communication from GOI to the states, based on the government decision over the recommendations of this Task Force
- Establishment of the Urban Health Mission Directorate & Secretariat and its strengthening, with placement of consultant/s and other supporting staff on contractual basis
- Organizing state/regional level capacity building workshops, from time to time, to help the states develop their Urban Health action plans and assist them in the inclusion of Urban Health component in the State RCH-II Project Implementation Plans (PIPs)
- Periodic review and intensive monitoring of processes of planning & implementation in the states; special focus for 18 priority states
- Document and disseminate UH programme experiences with the states in hard copy or in electronic form *viz.* share examples of (a) UH proposals of different types of cities, (b) approaches for conducting situational analyses of cities, (c) slum assessment and plotting

### **10.2 Suggested steps at the state level**

- Clear communication from State to the Districts as per the directives of State Urban Health Mission
- Establishment of State Urban Health Mission Directorate/Secretariat and its strengthening, with placement of appropriate personnel
- Inclusion of suggested members from the Department of Urban Development/Municipal Affairs (or its equivalent) in State Health Society/State Health Mission.
- Identification of at least 2 districts for initiating the UH Programme in the first year on the basis of relevant objective indicators.
- Organizing State Level Capacity Building workshops for municipal officials in order to sensitize them on their enhanced role in the backdrop of 74<sup>th</sup> Constitutional Amendment
- Ensure incorporation of the Urban Health component in the District Programme Implementation Plan (PIP).

### **10.3 Suggested Steps at the District level**

- Situational Analysis incorporating details of development indicators, health indicators, health facility survey and challenges in improving health care delivery
- Identification and mapping of slums and existing health facilities
  - a. Collection of slum lists from all the concerned departments viz. ICDS, health, municipal corporation, Pulse Polio Programme etc.
  - b. Reconciliation & consolidation of above slum lists to one slum list
  - c. Consultation with the AWW, ANMs, Ward Councilors, Sanitary Inspectors for identifying unlisted slums
  - d. Mapping of both, the listed and unlisted slums, indicating *inter alia* the health facilities.
- Stakeholders consultations for sharing the situational analysis and identifying the options for improving the health care delivery services
- Development of UH proposals including budget
- Final review of the UH proposals at District and State level
- Incorporation of comments and advisories given by District and State level UH Missions.

Government of India's guidelines for developing Urban Slum Health Projects has detailed information on the steps of UH Proposal development. A brief summary is enclosed as *Appendix – 6*.

# APPENDIXES

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## APPENDIX -1

### **Methodology adopted for computing Unit Cost Estimates for Urban Health Programme**

#### **1.0 Basic Principles**

- ❖ One primary health facility in urban areas i.e. Urban Health Centre will cover a population of 50,000. The current estimates are based on the assumption that out of the covered population of 50,000, there would be about 25000 slum and other vulnerable population while the rest would be non slum population.
- ❖ It is assumed that there would be one First Referral Unit (FRU) for 250,000 population. This Referral unit would correspond to the Community Health Centre with IPH Standards as envisaged in NRHM. As there are District hospitals and other Speciality hospitals in the urban areas, the FRU would be having only 20 indoor beds and would cover approximately 250,000 population. This is a deviation from the existing IPHS population coverage norm for a CHC as it is assumed that the government facilities would mainly be accessed by slum dwellers and other urban poor, while the better off could utilize the available private health care facilities.
- ❖ Community Mobilization activities are being planned primarily for slum population only. This implies that the provision of Link Volunteers and activities like *Nukkad Natak*, community contacts and other micro-level health promotion activities would be undertaken for slum dwellers only. However, macro level IEC/BCC activities and mass campaigns would be targeted to all, irrespective of slum or non-slum status.
- ❖ For the management of the community mobilization activities, one FRU along with the five UHCs (which would refer the patients) would form a 'Health Zone'. In order to manage the community mobilization activities, one NGO may be involved in a 'Health Zone'. Hence the cost of NGO involvement has been calculated for managing the community mobilization activities in the Health Zone only.
- ❖ In case of contracting out clinical, non-clinical or support services, there is no separate head for the reimbursement; the funds shall be paid from the same budget.

#### **2.0 Unit Cost Estimations for the primary health infrastructure (UHC) in Urban Areas**

The cost has been estimated under two heads

##### **2.1 Capital/Non-recurring**

Under the Capital/Non-recurring category, the cost for Equipment and Furniture has been estimated using the costing norms as proposed by the National Commission on Macroeconomics and Health (NCMH) for a Primary Health Centre (*Annexure VII page 145 of Report of the National Commission on Macroeconomics and Health*) and IPP-VIII (Delhi) norms.

It might be noted that in the urban areas, to the extent possible, new constructions for the UHC is discouraged. New centers can be opened in rented buildings as far as possible. The states may also consider to open up new centers wherever possible using the Public Private Partnership mechanism. However, in circumstances where there is no possibility for opening a new centre in rented building or through a PPP mechanism, preferably through a Not for Profit institution/charitable organization, if that may be feasible states can go in for construction of UHCs subject to due justifications and availability of government land at required locations (viz. in or in close proximity to slum

settlements). It may be noted that in no circumstances the cost of such new constructions includes more than nominal cost towards procurement of government land. Wherever the construction has to take place, the norms given in the NCMH Report may be followed; and the possibility of funds can also be explored from the local resources like industrial houses, business community, MLA and MP development funds etc.

This is being done based on the experience of the IPP VIII project, which was implemented in Bangalore, Hyderabad, Delhi and Chennai, as part of efforts to improve the service delivery for slum dwellers. The IPP VIII end line survey report noted that finding a suitable place for constructing a new UHC was a time consuming process and in all the cities, the health centers were started in rented buildings and in the later stages, when suitable space was available, new centers were constructed. The same principle can be applied while implementing the urban health programme. Moreover, the nature of slums makes them vulnerable to the proposition of rehabilitation; in that case, the locational appropriateness of the health centre could be questioned.

## **2.2 Recurring**

Under the recurring costs the cost for Human Resource, Drugs, Utilities and Building rent (wherever applicable) has been budgeted.

### **2.2.1 Human Resource**

The norms used for the Human resource, are based, on the norms for primary health infrastructure in IPP VIII project, and the suggestions of the members of the Task Force. In order to calculate the unit cost for involvement of the Human resource proposed the costing norms as proposed in the National Commission on Macroeconomics and Health has been used. It may be noted that all the human resource is being proposed on contractual basis and many states have developed their own norms for contractual staff. Hence, the cost being proposed is on the higher end and in order to maintain homogeneity in terms of payment to the contractual staff, the states can consider the norms as proposed by them for calculating the cost.

### **2.2.2 Drugs**

The cost worked out for the drugs is based on the estimates of the National Commission on Macroeconomics and Health.

### **2.2.3 Utilities**

Under the utilities head, the cost for Electricity, Water Supply, Telephone, Stationery and Maintenance & contingency has been budgeted. It may be mentioned that no amount has been budgeted for travel as the same has been budgeted under the outreach activities being proposed. The costing norm is based on the average expenditure incurred by the IPP VIII centers in Delhi. The states may make necessary adjustments using the local experience.

**Fund requirement of an Urban Health Centre (NEW CONSTRUCTION# BASIS) for Out Patient Care and Public Health for 5 Years**

#	Item	Norms	Duration (Months)	N os	Unit Cost*	Total Cost
<b>A. Capital/Non Recurring</b>						
1	UHC Building + Staff Quarters	4650 sft @ 600/sft	One time	1		2,790,000
2	Equipment	1 kit per health centre	One time	1	41,500	41,500
3	Furniture	5% of building cost	One time	1	139,500	139,500
	<b>Sub Total</b>					<b>2,971,000</b>
<b>B. Recurring</b>						
<b>1.0 Human Resource</b>						
1.1	Medical Officer	1	12	1	22,985	275,820
1.2	Pharmacist	1	12	1	12,810	153,720
1.3	PHN/LHV	1	12	1	14,265	171,180
1.4	ANM	4	12	4	11,355	545,040
1.5	Lab Technician	1	12	1	9,900	118,800
1.6	Computer Clerk cum Statistician	1	12	1	7,610	91,320
1.7	Peon/Chowkidar/Sweeper	3	12	3	3,500	126,000
	<b>Sub Total</b>			<b>12</b>		<b>1,481,880</b>
<b>2.0 Enhancing Service Delivery</b>						
2.1	Regular Outreach Clinic	1 per 5000 population	12	5 <sup>##</sup>	500	30,000
	<b>Sub Total</b>					<b>30,000</b>
<b>3.0 Drugs</b>						
		1 kit per UHC	1	1	300,000	300,000
	<b>Sub Total</b>					<b>300,000</b>
<b>4.0 Utilities**</b>						
4.1	Electricity		12	1	5,000	60,000
4.2	Telephone		12	1	1,000	12,000
4.3	Water		12	1	500	6,000
4.4	Stationary		12	1	1,000	12,000
4.5	Maintenance & Contingency		1	1	5,000	5,000
	<b>Sub Total</b>					<b>95,000</b>
<b>Sum Required for First Year (Recurring + Non-recurring)</b>						<b>4,877,880</b>
<b>Sum Required for remaining 4 Years</b>						<b>7,627,520</b>
<b>Total sum required for 5 Years</b>						<b>12,505,400</b>

# New construction shall be supported to a maximum of 20% of required Primary Level Facilities (UHCs).

## To cover an estimated urban slum population of 25,000 in a UHC area.

\* The unit cost of human resource has been mentioned here as the higher cap. The Unit cost has been calculated using the costing norms as used in the Report of the National Commission on Macroeconomics and Health (Annexure VII; pg.145). The states have already fixed the costing norms for different categories of Human resource to be taken on contractual basis; the same can be utilized for calculating the budget.

\*\* The unit cost for utilities has been calculated using the IPP VIII norms. The IPP VIII was the World Bank funded programme for strengthening the health care delivery for improving the quality of health care to slum dweller. Most of the states are now funding the cost of health facilities from their current budget after the withdrawal of World Bank funding.

\*\*\*The states must make an endeavour to start the facilities in rented buildings, however if new buildings are to be constructed then costing norms as used in the Report of the National Commission on Macroeconomics and Health (Annexure VII;pg.145) should be considered.

Note: Cost has been calculated using NCMH recommendations and IPP-8 (Delhi) Standards, while the staff pattern has been suggested by the members of the Task Force

## Fund requirement of an Urban Health Centre (ON RENTAL BASIS) # for Out Patient Care and Public Health for 5 Years

#	Item	Norms	Duration (Months)	No	Unit Cost*	Total Cost
<b>A. Capital/Non Recurring</b>						
1	Equipment	1 kit per health centre	One time	1	41,500	41,500
2	Furniture (estimated on the basis of cost of new building)	5% of building cost	One time	1	139,500	139,500
3	Repair, Renovation & modification of existing first tier facility		One time	1	200,000	200,000
<b>Sub Total</b>						<b>381,000</b>
<b>B. Recurring</b>						
<b>1.0 Human Resource</b>						
1.1	Medical Officer	1	12	1	22,985	275,820
1.2	Pharmacist	1	12	1	12,810	153,720
1.3	PHN/LHV	1	12	1	14,265	171,180
1.4	ANM	4	12	4	11,355	545,040
1.5	Lab Technician	1	12	1	9,900	118,800
1.6	Computer Clerk cum Statistician	1	12	1	7,610	91,320
1.7	Peon/Chowkidar/Sweeper	3	12	3	3,500	126,000
<b>Sub Total</b>						<b>1,481,880</b>
<b>2.0 Enhancing Service Delivery</b>						
2.1	Regular Outreach Clinic	1 per 5000 population	12	5 <sup>##</sup>	500	30,000
<b>Sub Total</b>						<b>30,000</b>
<b>3.0 Drugs</b>						
		1 kit per UHC	1	1	300,000	300,000
<b>Sub Total</b>						<b>300,000</b>
<b>4.0 Utilities</b>						
4.1	Electricity		12	1	5,000	60,000
4.2	Telephone		12	1	1,000	12,000
4.3	Water		12	1	500	6,000
4.4	Stationary		12	1	1,000	12,000
4.5	Maintenance & Contingency		1	1	5,000	5,000
<b>Sub Total</b>						<b>95,000</b>
<b>5.0 Building Rent</b>						
			12		12,000	144,000
<b>Sub Total</b>						<b>144,000</b>
<b>Sum Required for First Year (Recurring + Non-recurring)</b>						<b>2,431,880</b>
<b>Sum Required for remaining 4 Years</b>						<b>8,203,520</b>
<b>Total sum required for 5 Years</b>						<b>10,635,400</b>

# While making estimation, it has been presumed that about 80% of UHCs will operate either from rented buildings or through PPP mechanism.

## To cover an estimated urban slum population of 25,000 in a UHC area.

### **3.0 Unit Cost Estimation for the First Referral Unit/Zonal Hospital**

The cost has been estimated under two heads

#### **3.1 Capital / Non-recurring costs**

Under the Capital/ Non-recurring costs, the cost for Equipment and Furniture has been estimated using the costing norms as proposed in the Report of National Commission on Macroeconomics and Health (NCMH) for a CHC (*Annexure VIII page 146*). In the one time cost, the cost for construction of the new building is also being proposed, as in urban areas, it would be difficult to find an appropriate place to house the new FRU. Moreover the rented building would also require modifications in order to function effectively as an FRU. Hence, in the light of the above, new construction is being proposed. The cost estimates for the building, Furniture and equipments is again based on the cost estimates suggested by the National Commission on Macroeconomics and Health.

#### **3.2 Recurring Costs**

Under the recurring costs, the costs, for Human Resource, Drugs, and Utilities have been budgeted.

##### **3.2.1 Human Resource**

The norms for the Human resource have been adapted from the norms for primary health infrastructure in IPP VIII project, and the suggestions of the members of the Task Force. In order to calculate the unit cost for involvement of the Human resource, the costing norms as proposed in the National Commission on Macroeconomics and Health, have been used. It may be noted that all the human resources being proposed should be taken, as far as possible, on contractual basis and many states have developed their own norms for contractual staff. Hence, the cost being proposed is on the higher side, in order to maintain homogeneity in terms of payment to the contractual staff. The states can consider the norms as considered more appropriate by them for calculating the cost.

##### **3.2.2 Drugs**

The cost for the drugs is based on the estimates of the National Commission on Macroeconomics and Health.

##### **3.2.3 Utilities**

Under the utilities head, the cost for Electricity, Water Supply, Telephone, Stationery, Maintenance and contingency and ambulance support has been budgeted. The costing norms are based on the average expenditure incurred by the IPP VIII centers in Delhi. The states may make necessary adjustments using the local experience.

**Fund required for establishing new First Referral Unit/Zonal Hospital for 5 Years**

#	Item	Norms	Duration in months	No s.	Cost	Total Cost
<b>A. Capital/ Non Recurring</b>						
1	Building	4000 sft@Rs. 600/sft	One time	1	2,400,000	2,400,000
2	Staff Quarters (4-MOs, 4 Staff Nurses, 1-Chowkidar)	17200 sft@ Rs 600/sft	One time	1	10,320,000	10,320,000
3	Equipment	1 kit per FRU	One time	1	601,000	601,000
4	Furniture	(5% of construction cost)	One time	1	636,000	636,000
5	New Born Care Unit	1/Zonal Hospital	One time	1	558,400	558,400
<b>Sub Total</b>						<b>14,515,400</b>
<b>B. Recurring ( All the staff on contractual basis)</b>						
<b>1.0</b>	<b>Human Resource</b>					
1.1	Gynaecologist	1	12	1	26,268	315,216
1.2	Paediatrician	1	12	1	26,268	315,216
1.3	Anaesthetist	1	12	1	26,268	315,216
1.4	Public Health Programme Manager/Epidemiologist	1	12	1	26,268	315,216
1.5	Medical Officer	3	12	2	22,985	551,640
1.6	Pharmacist	1	12	1	12,810	153,720
1.7	Staff Nurse	9	12	9	12,810	1,383,480
1.8	Lab Technician	1	12	1	9,900	118,800
1.9	Radiographer	1	12	1	9,900	118,800
1.10	Statistical Assistant cum Clerk	1	12	1	6,650	79,800
1.11	Ward Ayah/Nursing Orderly	3	12	3	3,500	126,000
1.12	OT Attendant	1	12	1	5,500	66,000
1.13	Sweepers	3	12	3	3,500	126,000
1.14	Chowkidar cum Peon	2	12	2	3,500	84,000
<b>Sub Total</b>						<b>4,069,104</b>
<b>2.0</b>	<b>Drugs</b>	1 kit per facility	1	1	1,000,000	1,000,000
<b>Sub Total</b>						<b>1,000,000</b>
<b>3.0</b>	<b>Utilities</b>					
3.1	Electricity		12	1	20,000	180,000
3.2	Telephone		12	1	5,000	12,000
3.3	Water		12	1	3,000	36,000
3.4	Stationery		12	1	10,000	120,000
3.5	Maintenance & Contingency		1	1	30,000	30,000
3.6	Ambulance Support		12	1	20,000	198,000
<b>Sub Total</b>						<b>576,000</b>
<b>Fund required for the FIRST YEAR (Recurring &amp; Non- recurring both)</b>						<b>20,160,504</b>
<b>Fund required for the remaining 4 YEARS</b>						<b>22,580,416</b>
<b>Total Fund requirement for 5 Years</b>						<b>42,740,920</b>

\*\*If construction of new second tier facilities is required, NCMH norms may be considered.

#### **4.0 Unit Cost estimates for the NGO partnership to support community mobilization & IEC/BCC activities**

All community mobilization activities are primarily directed towards slum community only. As mentioned earlier, for the management of the community mobilization activities, one FRU/Zonal Hospital along with the five UHCs (who would refer the patients) would form a 'Health Zone'. In order to manage the community mobilization activities, one NGO may be involved in a Health Zone. Hence, the cost of NGO involvement has been calculated for managing the community mobilization activities in the zone only. The cost estimates have been done under the following heads.

##### **4.1 Human resource**

The NGO would depute a 'Zonal Coordinator' who would be responsible for managing the programme in the one 'Health Zone'. The Zonal Coordinator would be supported by 1 Statistical Assistant-cum-Clerk, 1 Administrative and Secretarial Staff and 5 Social Mobilizers. Each Social Mobilizer would look after area under one UHC.

##### **4.2 Community mobilization activities**

Under the community mobilization activities, the cost for Link Volunteer has been budgeted. The Link Volunteer would be appointed for slum population only. As part of the effort to strengthen the community and health provider interface, it is being proposed that a Link Volunteer shall promote and strengthen one Women's Health Committee in her slum area; the cost for strengthening them has also been budgeted. The costing norms for the above have been arrived using the experience of other urban health programmes in the country. The IEC/BCC activities have also been budgeted for slum population only, except for the promotional activities through mass media (Cable, Radio etc.), which will be targeted towards the entire urban population of a given area. The cost for IEC/BCC activities has been arrived at using the norms mentioned in the NCMH Report. The cost for the training of the Link Volunteers and WHC representatives has also been incorporated.

##### **4.3 Administrative support**

Under the administrative support, the provisions have been made for conveyance and institutional overheads like stationery.

### NGO Partnership: Operational Cost for 1 'Health Zone\*\*

Sl. No.	Description	Norm	Duration	No.	Unit Cost	Total Cost
<b>1.0 Human Resource Support</b>						
1.1	Zonal Coordinator	1 per 'Health Zone'	12	1	15,000	180,000
1.2	Social Mobilizer	1 per UHC	12	5	6,500	390,000
1.3	Statistical Assistant-Cum-Clerk	1 per 'Health Zone'	12	1	6,650	79,800
1.4	Administrative & Secretarial Staff	1 per 'Health Zone'	12	1	5,000	60,000
<b>SUB TOTAL</b>						<b>709,800</b>
<b>2.0 Community Mobilization Activities</b>						
2.1	Link Volunteer*	1 per 2000 population	12	65	1200	936,000
2.2	Mahila Arogya Samiti/Women's Health Committee***	1 per 2000 population	1	65	1500	97,500
2.3	IEC/ BCC activities like community level contact, Nukkad Natak, Publicity and dissemination through mass media, health awareness and promotion drives etc.	Rs. 5 per person	1	125000	5	625,000
2.4	Training to 10 - 12 Link Volunteers	7 Days Training	7	65	150	68,250
2.5	Training of WHC Representatives (3 Representative per WHC)	3 Days Training	3	195	100	58,500
<b>SUB TOTAL</b>						<b>1,785,250</b>
<b>3.0 Administrative Support Cost</b>						
3.1	Institutional overheads such as stationery, communications etc.		12	1	8000	96,000
3.2	Conveyance support to Zonal Coordinator	Rs. 2000 per month	12	1	2000	24,000
3.3	Conveyance support to Social Mobilizers	Rs. 500 per UHC Coordinator per month	12	5	500	30,000
<b>SUB TOTAL</b>						<b>90,000</b>
<b>TOTAL FUND REQUIREMENT FOR 1 YEAR</b>						<b>2,585,050</b>
<b>TOTAL FUND REQUIREMENT FOR 5 YEARS</b>						<b>12,925,250</b>

\*5 UHC and 1 FRU will constitute a "Health Zone".

\*\*The number of Link Volunteers has been calculated assuming that the slum population will constitute about 50% of the total Urban Population in the catchment area of a UHC.

\*\*\*To cover expenses inter-alia Durries, etc.

**Tentative Budget for a New Born Care Unit at Zonal Hospital in Urban Areas  
(Population Approximately 250,000)**

<b>Item</b>	<b>Number</b>	<b>Rate</b>	<b>Total</b>
Baby Warmer Servo Controlled	4	40000	<b>160,000</b>
Delivery room resuscitator with warmer (servo controlled), suction and oxygen system	1	50000	<b>50,000</b>
Bag and Mask System	4	1500	<b>6,000</b>
Endo-tracheal Tube (Assorted)	4	2000	<b>8,000</b>
Laryngoscope	4	500	<b>2,000</b>
Phototherapy Units	2	15000	<b>30,000</b>
Oxygen Hoods	4	600	<b>2,400</b>
Baby Suction Machine	1	15000	<b>15,000</b>
Room Heaters	2	1500	<b>3,000</b>
Pulse Oxymeter	1	70000	<b>70,000</b>
Electronic Weighing Machine	1	12000	<b>12,000</b>
Civil Work	1	200000	<b>200,000</b>
<b>Total</b>			<b>558,400</b>



## **APPENDIX-2**

No. R. 14011/4/2005-EAG (Pt)  
Government of India  
Ministry of Health & Family Welfare  
Department of Health & Family Welfare

Nirman Bhawan, New Delhi  
Dated the 6<sup>th</sup> June 2005

### **ORDER**

It has been decided to constitute a Task Force to advise the National Rural Health Mission (NRHM) on strategies for Urban Health Care. The members and terms of Reference of the Task Force shall be as follows:

#### **Members:**

1. Sh. B. P. Sharma, Joint Secretary, M/o HFW, GoI – Convener
2. Sh. Chaman Kumar, Joint Secretary, D/o Women & Child Development, GoI
3. Sh. A. K. Shiva Kumar, Member NAC
4. Professor C. S. Panday, Professor of Community Medicine, AIIMS
5. Dr P. Padmanabhan, JD (RCH), Govt. of Tamil Nadu
6. Dr Siddharth Agarwal, Country Representative, USAID-EHP Urban Health Programme
7. Dr N. G. Gangopadhyaya, Advisor (Health), SUDA, Kolkata
8. Dr Nandita Kapadia Kundu, Additional Director, Institute of Health Management, Pune
9. Dr Mala Ramachandran, Director, Urban Health & Training Institute, Bangalore
10. Shri Biren Dutta, Commissioner & Secretary (HFW), Government of Assam
11. Dr S. K. Satpathy, DC (ID), M/o HFW, GoI
12. Dr V. K. Manchanda, DC (MH/CH), M/o HFW, GoI
13. Dr Mahavir Singh, Director (H&UD), Planning Commission
14. Sh. S. C. Sharma, Director M/o Urban Employment & Poverty Alleviation, GoI
15. Sh. T. V. Raman, Director, M/o HFW, GoI – Rapporteur

#### **Terms of Reference:**

1. To recommend appropriate modalities and strategies for providing affordable, efficient and cost effective delivery of quality health care services to urban poor; also to recommend additional/specific measures and strategies, as deemed appropriate, for providing a focused attention in this regard to the 18 high focus states identified under National Rural Health Mission (NRHM).
2. To review the current roles and capacities (manpower, financial and professional) of the Municipal Bodies to provide healthcare services in urban areas, and suggest feasible and effective strategies to integrate them, as required, in a harmonious

manner with the urban health care related activities/urban RCH Programme undertaken by the Health & Family Welfare Departments in the States/Union Territories.

3. To suggest feasible and sustainable methods and strategies for promoting inter-sectoral convergence between the Health & Family Welfare Departments on one hand, and related Departments/Sectors such as Education, Women & Child Development, Urban Development/Urban Affairs, Social Welfare etc. on the other.
4. To suggest optimal and suitable strategies for forging, strengthening and sustaining the aspect of Public Private Partnership (PPP) involving inter-alia the NGOs and other private providers, with a view to facilitating an efficient and cost effective implementation of urban health projects.
5. To suggest a Roadmap and detailed costing for additional activities proposed by the Task Group, and annual breakup for the same.

The Task Force would be required to submit its report within a period of three months from the date of its constitution.

The non-official members of this Task Force will be entitled to TA/DA with regard to official visits made/tour undertaken by them in this connection in accordance with relevant/admissible Government of India rules.

The Task Force can co-opt other members as per felt needs.

This issues with the approval of Secretary (Health & Family Welfare).

Sd/-  
SHUBHRA SINGH  
Director (NRHM)

To all members of the Task Force

Copy to:

1. All members of the Mission Steering Group/Empowered Programme Committee
2. AS/JS in the Ministry of Health & Family Welfare
3. Joint Secretary, Prime Minister's Office
4. Deputy Secretary, National Advisory Council
5. EAG Bureau

## **APPENDIX-3**

L.19017/7/2005-APS  
Government of India  
Ministry of Health & Family Welfare  
(Department of Family Welfare)

Nirman Bhawan, New Delhi  
5<sup>th</sup> August, 2005

**Subject:** Constitution of Task Force to advise the National Rural Health Mission (NRHM) on Urban Health Care – Sub-Group Meetings scheduled for 11.08.2005 (Thursday) and 17.08.2005 (Wednesday)

The First Meeting of the above Task Force was held on 1<sup>st</sup> August, 2005 wherein it was decided inter-alia to constitute two Sub-Groups for detailed deliberations on the various issues to provide quality health care to Urban Population. The composition and Terms of Reference of the Sub-Groups are as under:-

### **Sub-Group -1**

1. Professor C. S. Pandav, Professor of Community Medicine, AIIMS, New Delhi
2. Dr Siddharth Agarwal, Country Representative, USAID-EHP Urban Health Programme, Vasant Vihar, New Delhi
3. Dr Nandita Kapadia Kundu, Additional Director, Institute of Health Management, Pune
4. Dr Mala Ramachandran, Director, Urban Health & Training Institute, Bangalore
5. Dr Gauri Pada Dutta, Member, State Planning Board, Development and Planning Department, Government of West Bengal
6. Dr S, K. Satpathy, DC (ID), M/O HFW, GoI

### **Terms of Reference**

- Process identification of the target beneficiaries viz. slum dwellers, pavement dwellers, temporary settlers like brick kiln workers, mine workers, construction workers etc.
- Types of services to be provided
- Review of existing infra-structure and suggesting modifications, if any, deemed necessary in the existing pattern and norms for urban areas
- Suggest appropriate health infrastructure for urban slum areas i.e. level/tier system, physical infrastructure, manpower, drugs, equipment etc.
- System of referral linkages
- Costing based on norms
- Monitoring and evaluation mechanisms
- Any other related items

### **Sub-Group – 2**

1. Sh. Chaman Kumar, Joint Secretary, D/o Women & Child Development, GoI, Shastri Bhawan, New Delhi
2. Dr P. Padmanabhan, Joint Director (RCH), Dte. of Family Welfare, DMS Complex, 259 Annasalai, Chennai (Telefax – 4320563)
3. Dr N. G. Gangopadhyaya, Advisor (Health), SUDA, Ilgus Bhawan, Kolkata
4. Sh. S. C. Sharma, Director M/o Urban Employment & Poverty Alleviation, GoI, Nirman Bhawan, New Delhi
5. Dr B. C. Das, Director SIHFW, Government of Orissa, Bhubaneswar
6. Dr Sanjeev Upadhyaya, US AID-EHP, New Delhi

7. Sh. Savitur Prasad, Director, Ministry of Urban Development, GoI
8. Dr Gurpreet Singh, MCD
9. Sh. T. V. Raman, Director, M/o HFW, GoI

#### **Terms of Reference**

- To examine institutional framework in target areas and suggest suitable measures with regard to Urban Health in the backdrop of NRHM Framework
- Inter-sectoral linkages and coordination between various service providers in urban areas
- Funds availability under HFW, Urban Development, Women & Child Development and Municipal Corporation and fund flow mechanism, including funding support available from 12<sup>th</sup> finance commission (wherever applicable)
- Public Private Partnership
- Requirement of additional infrastructure, including manpower as per norms
- Additional measures, if any desired, for 18 high focus states under NRHM
- Any other related norms

The Task Force also decided in its first meeting that the meeting of Sub-Group 1 be held on 11.08.2005 and that of Sub-Group -2 be held on 17.08.2005. Accordingly, it has been decided to hold the meeting of Sub-Group -1 at 11.00 AM on 11.08.2005 (Thursday) in Room No. 106, D Wing, Nirman Bhawan, New Delhi and that of the Sub-Group – 2 at 11.00 AM on 17.08.2005 (Wednesday) in Room No. 106, D Wing, Nirman Bhawan, New Delhi.

You are requested to kindly make it convenient to attend the meeting concerning your Sub-Group. The non-official members of this task force will be entitled for TA/DA for attending the meeting as per relevant rules. It is requested that a line in reply confirming your participation in the meeting may kindly be sent at your earliest convenience.

Sd/-  
(T. V. Raman)  
DIRECTOR (AP)  
Telefax No. – 23063523

Copy to:

1. All the members of Sub-Group 1 & 2
2. Copy for information to JS (BPS), M/o HFW, GoI

**APPENDIX - 4**

L.190 17/7 /2005-APS  
Government of India  
Ministry of Health and Family Welfare  
(Department of Family Welfare)

Nirman Bhawan, New Delhi  
August 10, 2005

To

**Subject:** Minutes of the 1st meeting of Task Force to advise NRHM on strategies for Urban Health Care held under the Chairmanship of Sh. B.P. Sharma, JS (BPS) at Nirman Bhawan on August 1, 2005.

\*\*\*\*

Sir,

I am directed to enclose herewith a copy of the Minutes of the meeting, mentioned above held under the Chairmanship of Sh. B.P. Sharma, JS (BPS) at Nirman Bhawan on August 1, 2005.

For your kind perusal and necessary action.

Sd/-  
(REKHA CHAUHAN)  
Under Secretary (AP)  
Phone 011- 2306 2959



**Minutes of the first meeting of the Task Force to advise NRHM on ‘Strategies for Urban Health Care’ held under the convenorship of Shri B. P. Sharma JS-BPS at New Delhi on August 1, 2005 (Monday)**

A list of participants is enclosed vide Annexure I.

1. At the outset, Shri B. P. Sharma, the convener of the Task Force welcomed all the participants to the meeting and gave a detailed overview of the salient features of the National Rural Health Mission (NRHM) as also about the primary objectives/purposes underlying the constitution of this Task Force. Thereafter, Shri T.V. Raman (Director AP) made a presentation on “Developments so far on Urban Health “. This was followed by another presentation on “*Working with states & cities for furthering health of urban poor: Experiences and some issues for consideration*” by Dr Siddharth Agarwal.
2. Subsequent to the above mentioned elaborate presentations covering a host/wide gamut of issues pertaining to Urban Health spanning the past, present as also the likely future scenario, the task force had extensive and threadbare discussions concerning various aspects of work and task assigned to it under the terms of reference. As a sequel thereto, the following decisions were taken by the Task Force with regard to the future courses of action to be pursued in the matter so as to be able to accomplish the tasks assigned to the Task Force in a qualitatively good and timely manner:
  - A. Since the time available to the Task Force for completion of the assigned responsibilities is extremely limited while the tasks to be finished themselves are of considerable magnitude and complexity, it was unanimously agreed that the task force would have to work on a top priority basis during the limited time available for comprehensively and effectively addressing the various items figuring in the terms of reference of the group.
  - B. In view of the rather complex nature and wide spectrum of various relevant issues to be addressed by the Task Force, based on suggestions received from the Members, it was decided to make the following modification and additionalities with regard to the original composition of the Task Force by invoking the relevant powers vested with the Task Force:
    - a. **Modification:** The status of Dr B. C. Das, Director, SIHFW, Bhubaneswar to be revised from that of “Special Invitee” at present to “Member”.
    - b. Additional Members to be included in the Task Force:**
      - i. Dr Masee Bateman, Sr. Advisor in Child Health, USAID
      - ii. After noting that the Task Force has representations from several State Governments/Organizations under them in terms of Tamil Nadu, Assam and West Bengal, it was decided to include, in the Task Force as a member, Dr Gurpreet Singh, Incharge MIS Cell, MCD, Delhi (with a view to enhancing the representation for Municipal Corporations in the Task Force)
      - iii. Shri Savitur Prasad, Director, Ministry of Urban Development, Government of India (in response to suggestions from several members that there is an imperative need to have in the Task Force an expert dealing with Water Supply Sanitation in the urban areas.

- iv. Since one of the Task Force Members, namely Dr A. K. Shiva Kumar (who is also a Member of the National Advisory Council) has expressed his inability to participate in the proceedings of the Task Force till end of August, 2005, an additional Member from the list of Health Professionals of the Mission Steering Group of NRHM, viz. Dr Gauri Pada Dutta, Member, State Planning Board Government of West Bengal shall also be inducted onto the task force.
3. In view of the limited time available to the Task Force, with a view to facilitating its work, it was decided to constitute two sub groups, namely, sub group 1 and sub group 2 as per the details of the composition and terms of reference contained in Annexure II. It was also decided that the meeting of sub group 1 be held in New Delhi on 11.8.05 (Thursday) while that of Sub Group 2 be held at New Delhi on 17.8.05 (Wednesday). As soon as these two sub groups are able to finalize their reports and recommendations in relation to their respective TORs, the next meeting of the Task Force could be convened to deliberate on these and take a view regarding the finalization of the report of the Task Force.

The meeting ended with the vote of thanks to the Chair.

Annexure -1

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#### **LIST OF PARTICIPANTS**

1. Shri. B. P. Sharma, Joint Secretary, MOHFW –GoI - Convener
2. Shri Chaman Kumar, Joint Secretary, Department of WCD- Government of India
3. Dr S. K. Satpathy, DC (ID), MOHFW- Government of India
4. Shri T.V. Raman, Director (Area Projects), MOHFW –GoI (RAPPORTEUR)
5. Shri S.C. Sharma, Director, Ministry of Urban Employment & Poverty Alleviation, GoI
6. Dr Mala Ramachandran, Director, Urban Health Resource & Training Institute, Bangalore Municipal Corporation, Bangalore
7. Dr Nandita Kapadia Kundu, Assistant Director, IHMP, Pune
8. Dr B. C. Das, Director SIHFW, Government of Orissa
9. Dr Himanshu Bhushan, Maternal & Child Health Division, MOHFW, GoI
10. Dr Siddharth Agarwal, Country Representative, USAID-EHP, New Delhi
11. Dr Sanjeev Upadhyaya, Consultant Public Health, USAID-EHP, New Delhi
12. Mrs. Rekha Chauhan, Under Secretary, AP Division, MOHFW, GoI
13. Shri. R. N. Yadav, Desk Officer, AP Division, MOHFW, Government of India
14. Shri Sunil Kansal, Section Officer, AP Division, MOHFW, GoI
15. Ms. Anita, AP Division, MOHFW, Government of India

**Minutes of the Meeting held on 25.11.2005 (Friday) of The Task Force “To advise the NRHM on Strategies for Urban Health Care”**

At the outset, Shri B.P. Sharma, Joint Secretary, MOHFW, Government of India and Convener of this Task Force welcomed all the members of the Task Force to the Meeting and thanked them heartily for taking out some of their precious time, amidst their other pre-occupations and busy schedules, to be able to participate in this important meeting. Thereafter, he provided an overview of the work so far accomplished by this Task Force and the two sub groups set up there under. A list of participants who attended this meeting is enclosed.

Thereafter, Shri T.V. Raman, Director, MOHFW and Rapporteur of the Task Force made a detailed and comprehensive presentation on the draft report of the working group, which had been circulated earlier amongst the members and which was the scheduled agenda document to be discussed at the meeting. He mentioned inter alia that the first meeting of the Task Force was held on August 1, 2005 wherein, among other things, a decision had been taken to set up two sub-groups, namely, sub group I and sub group II for going threadbare into various items figuring in the ToR of the Task Force and coming up with suitable recommendations thereon, with a view to facilitating the mandated work of the Task Force. He also informed that while sub group I had met on August 11, 2005, the other sub group had its meeting on August 30, 2005. He further informed that the draft report of the Task Force, prepared by the Secretariat and circulated amongst the members as the agenda document for this meeting was, in fact, prepared largely on the basis of the detailed work performed earlier by the two sub groups and their reports based thereon. He also drew attention to the fact that the material contained in the draft report was also based on several informal meetings and discussions had by the secretariat with various members of the Task Force through informal discussions and e-mail communications. Following the aforementioned presentation by Shri T.V. Raman, the Task Force had elaborate discussions and detailed deliberations concerning various aspects of work mandated to it under its Terms of Reference. While doing so, the Task Force members also took due cognizance of various other allied and associated issues which have a bearing/impact on issues relating to urban health care under the framework of NRHM. **The following is a gist of the major/substantive issues discussed, suggestions made and agreed by the members and decisions taken.**

**Shri B. P. Sharma, Convener:**

- He complemented the secretariat for the painstaking work done in this regard, culminating in the preparation of a fairly comprehensive and well-articulated draft report of the Task Force.
- Since the basic underlying intent/objective is to ensure that the urban poor get/receive their due and deserved attention under NRHM, we need to ensure that the recommendations eventually made by this Task Force are comprehensive and effective enough to accomplish this core objective.

- The cost estimates/financial implications details, as currently contained in the draft report, need to be made sharper and more elaborate, based on objective principles as also, wherever relevant and appropriate, on the various norms given in its report (August 2005) by the National Commission on Macro Economics and Health. While undertaking this exercise, the objective should be to cater adequately and effectively to the growing health requirements of urban population as a whole instead of being targeted at only the urban poor. For this purpose, he opined that certain knowledge and cost related estimates available already based on past urban city health projects undertaken and completed can also be optimally made use of.

#### **Dr Shiv Kumar**

- He congratulated and complemented the secretariat for managing to put together such a comprehensive and well articulated draft report. He endorsed the suggestion made to change the name of “National Rural Health Mission” to either “National Health Mission” or “National Public Health Mission”. He further added that a title like ‘*NRHM extended to urban areas*’ looks a little inappropriate in terms of its meaning and the associated focus. Therefore, the NRHM may be rechristened as “National Health Mission” or “National Public Health Mission”.
- He strongly felt that Malnutrition, Water and Sanitation & HIV are some of the basic and ever expanding problems in urban areas these days and therefore, there is an immediate, imperative and formidable challenge to effectively address and appropriately amalgamate them rather than leaving them to stand aloof and to remain on the back-burner.
- There is a definitive and urgent need to provide for adequate supply of “need-based drugs and supplies” since, many a time, it is seen that the medicines prescribed are not/cannot be bought by the poor people for reasons of financial capacity and affordability.
- The working hours of the urban health centres should be such that, besides any other appropriate timings that may be stipulated for the purpose, they must remain available/open at least for a few hours each before 10 A.M. after 6 P.M., keeping in view the convenience of the target population in urban areas.
- Link Volunteers could be considered for being paid some honorarium and selection.
- Federation of ASHAs/Link Volunteers is indeed a welcome idea and their representatives ought to find a place/membership on various levels of UH Committees at district, state and national levels. Such federations could also be enabled to have a say and contribute their ideas to decision making at various stages of the process, starting from planning/project formulation and extending up to effective implementation (more from a client prospective) and monitoring of the plans drawn up.
- Involving social work schools in the urban health programme needs to be considered, given their substantial unexploited potential to contribute to health care projects in the country. Outreach services should become an essential part of education curriculum in the medical colleges. Apart from medical colleges, other educational institutions like Social Science Colleges and Universities should also be appropriately invoked and involved in addressing the social dimensions of health in different capacities.
- To expect/demand uniform proposals for all the urban areas even within a state would be unrealistic/ inappropriate since there are substantial inter-city and intra-

city differences. Situational analysis and mapping as proposed in the report is therefore, an ideal way of proceeding further, as an interim arrangement, till such time appropriate systemic arrangements and statistical systems are put in place to generate reliable, reasonably up to date and timely urban health data in the country at defined/periodic intervals of time.

- Innovative methods should be encouraged to urge the urban areas/local areas to evolve appropriate methods of cross subsidization, keeping in view inter-alia the resource constraints at the Government level as also the paying capacity of the clients.

#### **Dr C. S. Pandav**

- Supported the renaming of the Mission to either “National Health Mission” or “National Public Health Mission”, the latter one being the more preferable one between the two, keeping in view the ground realities and demands of time,.
- Drug supply needs to be ensured at urban health facilities since often, about 50% of the costs incurred by poor population in seeking health care goes towards purchase of drugs.
- There is an urgent and imperative need for documenting and disseminating the best practices in the formulation and implementation of urban health projects from the experiences gained across the country for the benefit of various States/UTs. Such an exercise is best executed by MOHFW, GOI and that too, not just as a one time exercise but instead rather on a periodic and continuous basis.
- There are about 250 medical colleges in the country, a sizeable share of which is located in urban areas. The urban slums can provide and serve as a potential field area/laboratory for the medical students to gain a first hand knowledge and appreciation of the types and dimensions of the health problems faced by the urban poor and the various effective options/methods available for dealing with those. In view of this, it would be prudent and purposeful to have a policy whereby the various medical colleges located in and around urban areas can be mandatorily required to adopt some urban slums in their vicinity/proximity.
- Operational research, training of health team and monitoring of urban health programmes could be some of the mandated responsibilities for medical colleges.
- Besides standard/stipulated in-built systemic arrangements for Monitoring and Evaluation (M&E), it would also be useful to take recourse to the option of “M&E” by independent external agencies, in the larger interests of programme implementation, from a client satisfaction point of view.

#### **Dr Karuna Singh**

- Apart from process indicators, there is also a need to clearly spell out the outcome indicators to be accomplished within specified time frames/time limits.
- There is a definite need for convergence between the ensuing National Urban Renewal Mission (NURM) and NRHM (in urban areas) at all levels since both would be working towards some of the overlapping objectives, at least in about 60 towns where NURM is being launched on December 3<sup>rd</sup>, 2005.

#### **Dr Nandita Kapadia Kundu**

She deeply appreciated the draft report of the Task Force prepared by the secretariat, describing it as a comprehensive and well-formulated one from the standpoint of addressing the needs of the poor beneficiaries in urban areas.

- For the effective monitoring of implementation of the proposals made by this Task Force and subsequently accepted by the Government, a separate section could be included in the report exclusively focusing on the “M& E” dimensions. Apart from that, some process indicators could also be looked at such as the following:
  1. No. of states or districts in the state which have set up UH Cells
  2. No. of cities which have initiated UH Programme
  3. No. of Steering/Programme Committee meetings held at District/State level.
 

The Task Force may also suggest/indicatively mention a desired frequency for undertaking such programme review tasks.
- Gender issues need to be brought out more clearly and more emphatically in the report, along with a mention of the serious problem of diminishing child sex ratios.
- Representatives of civil society, ASHA Federations, AWW Federations, Slum Dweller Federations/Associations, corporate sector, NGOs and community representatives should be on the UH programme committees at all levels *viz.* National, State and District level. They should be involved starting right from the stage of the planning and policy formulation and going up to the point of implementation and monitoring.

#### **Dr Mahavir Singh**

- Education and Environment should also be an important part of the concerns addressed by the Task Force.
- District level bodies need to be headed by the DMs preferably; city level bodies should be headed preferably by the highest elected representative in the district.
- Urban poor should be the focus and not merely ‘slums’; further, focus ought to be also on the ‘ward committee’ because it is already an existing entity.
- Experiences in 4 districts of Haryana where a pilot project (named VIKALP) is being attempted can be used for designing programmes based on Public Private Partnership, whereby deliveries are free for the health card beneficiaries and Rs. 500 is reimbursed to the beneficiary, and Rs. 1500/- for caesarian section to the private obstetrician and Rs. 500/- for the anesthetist is reimbursed. The medicine supplies are provided by the State Government for these beneficiaries. Beneficiaries are selected on the basis of BPL status. The other States/UTs can consider adopting such a model, whenever required, with whatever local area induced variations that may be called for therein.
- Oral Health is one of the neglected aspects in both, rural as well as urban areas. Therefore, if resources (both financial and manpower/equipment availability) permit, it should be covered under the service package, at least in urban areas, since the availability of dentists is easier to ensure in urban areas in comparison to rural.

#### **Dr Siddharth Agarwal**

- Presence of the urban poor extends beyond urban slums. Therefore the health services should be extended beyond merely the listed urban slums.
- Joint sub-missions on Nutrition (with WCD), Water Supply & Sanitation (with water resources) & HIV/AIDS (with NACO) could be explored for their possibilities.
- Effective systemic/in-built arrangements need to be installed to ensure accountability at all levels of urban health project formulation and implementation.

**Dr Gurpreet Singh**

- The planning for the health facility is better based on population norm (i.e. 50,000) instead of on slum or ward as the basis. It is often difficult in urban areas to segregate slum areas from non-slum areas.
- ANMs availability on a full-time basis needs to be ensured in urban areas, particularly before 10 AM and after 6.00 PM. Ideally, she should belong to the same locality or else a nearby one from the standpoint of availability.
- Arranging for adequate capacity at I tier facilities to respond to both communicable diseases and non-communicable Diseases is quite a stupendous and arduous task; never the less, it has to be addressed effectively enough.

**Dr Mala Ramachandran**

- For PPP in urban areas, we could utilize private facilities and work out the specifics/details of cost sharing, equipment sharing, space sharing etc. The rates for various services provided under PPP should be reasonable and would have to be fixed on the basis of cross subsidization principles, keeping, among other things, in view the differentials in the capacities to pay and bear/afford treatment costs.

**Shri B. P. Sharma**

Responding to detailed deliberations had in the meeting with regard to PPP, the convener of the Task Force, reflecting the consensus view of the Task Force that emerged in the matter, clarified that, whenever/wherever there is an already created/existing government health infrastructure, it should be optimally utilized (if required), after correcting maladies, if any, and only in cases/situations where this option is either not feasible or inadequate, the PPP options/modalities need to be explored and exploited, to the utmost possible benefit of the target population.

- For the greater accountability of Public Health System, PRIs are being involved in NRHM at all levels as the Chairman, Zilla Parishad is the chairman of District Health Missions under NRHM. A similar kind of arrangement needs to be thought of for urban areas.
- In the long run, the public sector health infrastructure in urban areas also needs to be strengthened in terms of standards which are comparable with Indian Public Health Standards under NRHM.

**Dr Mahavir Singh**

- As regards PPP, the Private sector representatives also need to be involved in stakeholders' consultations. Rates of different service packages ought not be decided unilaterally by the government agencies under PPP.

**Dr S. K. Satpathy**

- There is an urgent need to facilitate the process of building strong community participation/mobilization and structure for primary health care services and referral linkages. PPP aspect in the report needs to be spelt out in greater/adequate details. If feasible, an effort should be made to include some preventive aspects as well.

**Shri B. P. Sharma**

- The Government is committed to providing required urban health structure and care across the country; therefore, the planning for the purpose has to be made, keeping in view the requirements of all the cities and towns spread across the country.

**Dr P. Padmanabhan**

- For making PPP functional, commitments should be extracted from the State Governments in terms of initiations, effective execution, smooth running and sustainability of the urban health projects taken up from their own resources in the long run.
- Budget allocations for UH through Flexi Pool are not sufficient. The finance allocation for UH should be made through separate head just like is the case with Immunization.
- Smaller municipalities have problems of funds; states should work out mechanisms to support the UH programme in such areas.
- Emerging new diseases, which especially affect the urban areas such as Dengue, Leptospirosis and HIV/AIDS should also be considered to be addressed under UH Programme.

**Dr A. K. Shiv Kumar**

- Innovations and speedy implementation are to be encouraged and given top priority. The NRHM has a life of 7 years (2005-2012). There would be only about 6 years time available under NRHM for urban health programme. The challenge is therefore, to devise ways and means of achieving the urban health tasks within this limited span of time. The following need, in particular, focused attention:
  - Quality Access,
  - community mobilization,
  - tangible outcomes for women and children (clearly defined universal immunization, women's health),
  - monitoring and reporting
- Simple interventions like immunization, TT Vaccination, Antenatal Care, Nutritional interventions need to be intensified immediately since these might not require many new processes to be initiated afresh and installed.
- The presence of Non-governmental organizations is stronger in Urban Areas in the country and therefore, appropriately and optimally involving them in the UH task would be desirable.

**Dr G. P. Dutta**

- Enough publicity should be done to inform the target population in urban areas about the urban health programme in the country and its salient features.
- Different states have different characteristics; states should determine their choice of urban health models based on broad guidelines. Adequate flexibility must be given to the states in implementing UH programme.
- The initial effort should be to optimize the utilization of available public sector infrastructure in urban areas, rather than to incentivise inefficiency; however, in the absence/in the event of inadequacy of such infrastructure, partnerships with private partners could be sought.

- Morbidity profile/pattern of the common ailments of slum community can be determined through participatory neighborhood surveys. It will not suffice to know only about the disease pattern.
- Indian system of medicine and homeopathy are not ancillary to the allopathic system and survive on their own strengths/merits. The target urban poor population is often treated by quacks of all these streams, particularly the allopathic. Therefore, we must take note of RMPs, and rationalize these through health education and leave it for the people to decide/choose from amongst the various streams.
- Leaders of civil society (including trade unions, mass organizations, political/elected representatives) should also be consulted and their services/roles used appropriately, given their qualities and capabilities as change agents in their respective communities/societies.
- After finalizing the report of the Task Force, it should be shared with the states for endorsement or else, comments; due consultations should be held with the states before finalizing the strategies for urban health care to be embedded into NRHM.

#### **Dr Siddharth**

- There can be a broader one National Health Mission which will have 2 sub-missions *viz.* National Rural Health Sub-mission and National Urban Health Sub-mission for urban and rural communities respectively.
- Each Sub-mission shall have representation given also to sectors such as water & sanitation, nutrition etc. which are, in a sense, key determinants to health.
- **Since urban health is still a relatively new/emerging subject, at this stage, it desperately needs a strong support, nurturing and backup from the Government side so as to acquire the required levels of support and momentum in various states and get placed on a proper trajectory. In view of this, there is a strong and urgent case for taking “Urban Health” out of the domain of the flexi-pool component of RCH II under NRHM and instead giving it the status of an exclusive, standalone entity which should receive dedicated and priority attention of the government agencies at all stages of the process starting from project formulation/initiation, going through the implementation phase and extending up to the stage of monitoring and evaluation.**

#### **Shri B. P. Sharma**

- Necessary costing/financial and time line details would need to be worked out for preparation of urban health related components of the EFC Note for NRHM. Such financial requirements will have to be worked out for the complete domain of country’s urban areas rather than being confined only to urban slums.
- In order to facilitate and expedite the process, the recommendations and draft guidelines prepared by MOHFW need to be shared and feedbacks taken thereon from them. Their feedbacks could be incorporated appropriately in the final guidelines, depending on the merits found therein.
- Like NRHM and other National Health Programmes, Urban Health Sub-mission’s literature should be given due and wide publicity by the MOHFW.
- MOHFW should work out some norms for accreditation of urban area based private doctors/health centres/hospitals/diagnostic centres, which is one of the key determinants for the operation of PPP in urban areas.

- The Task Force endorsed the key recommendations contained in its draft report, which was discussed, as the agenda document, at the meeting.
- The Task Force desired to place on record its deep sense of appreciation for the excellent support (both administrative and technical) extended to it in its task by the Area Projects Division of the MOHFW in its role as the secretariat to the Task Force. Likewise, the Task Force wished to heartily thank some other officials, notably, Dr Karuna Singh of MCD and Dr Sanjeev Upadhyaya, Shri Anuj Srivastava and Ms. Shivani Taneja of the Urban Health Research Centre of USAID for their significant and very useful contributions to the work of the Task Force as also of the two sub-groups set up their under.
- The Task Force to cognizance of the fact that the Ministry of Urban Development, Government of India is planning to launch National Urban Renewal Mission (NURM) on 3<sup>rd</sup> of December 2005, which is likely to be implemented in about 60 (million plus) Cities/as also some other cities of the Country which are known for their religious/historic importance or are significant from the tourism angle. The Mission viz. NURM is expected to give focused attention inter-alia to the integrated development of urban infrastructure and services, with special emphasis on provision of basic services to the urban poor, including housing, water supply, sanitation, slum improvement, community toilets/bath, etc. There should be an effort to integrate the Mission for UH under the NRHM with its counterpart under NURM, once the NURM programme is launched officially. For this purpose, MOHFW, through the convener of this Task Force, can hold necessary discussions with the concerned senior officials handling NURM to explore possibilities of integrating the two mission groups for these missions in a mutually acceptable/agreed manner to avoid unnecessary overlapping/duplication of efforts between these two missions as also ensure consistency and coherence in the directions issued by these two mission steering groups.

The Task Force decided that, after the NURM is launched on 3.12.2005, the essential features thereof must be shared with the Task Force members to enable the Task Force to firm up and finalise its views and recommendations before submitting its report to the Government. In view of this, the Task Force advised the secretariat to seek the requisite approval of the competent authority for obtaining an extension for the term of the Task Force for a period of two months beyond the currently sanctioned term, which, expires on December 5, 2005. It was also decided that there would be no need for calling any more meeting of the Task Force and that the process for approval of the final report of the Task Force will be one whereby the secretariat would subsequently send the suitably amended version of the Task Force Report by e-mail/other efficient means and the members shall respond thereto with their comments if any and/or concurrence within a period of about ten days.

#### **List of the participants:**

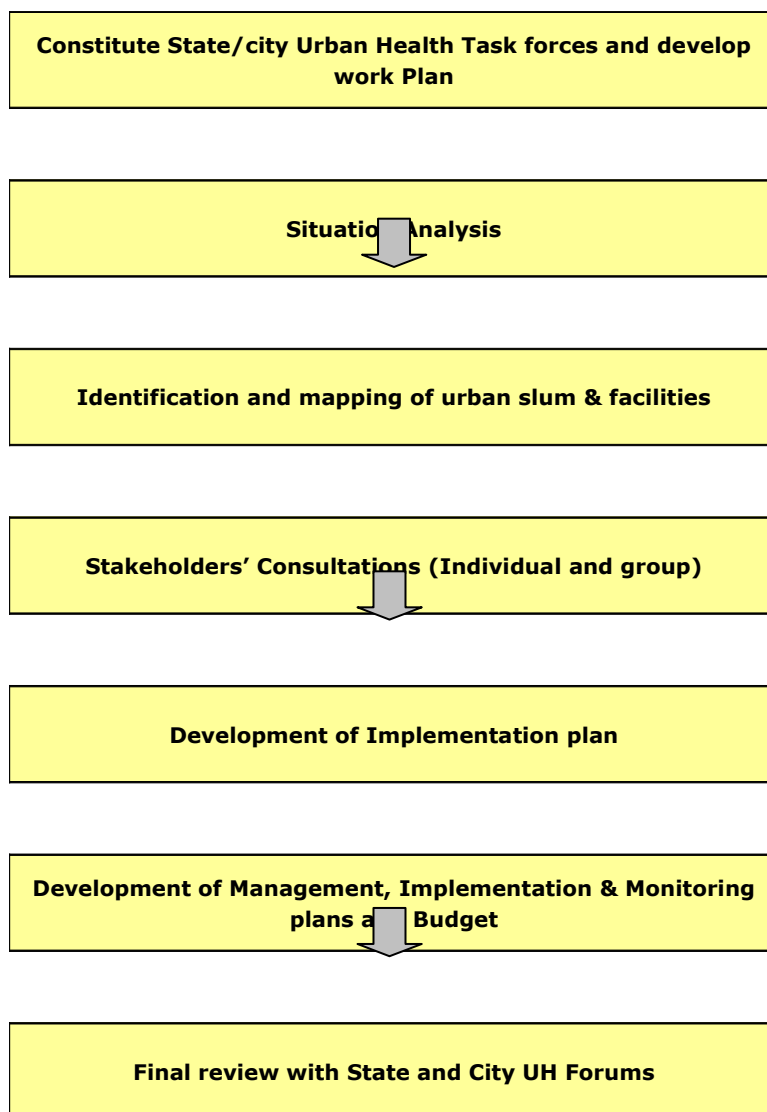
1. Shri B. P. Sharma, Joint Secretary, MOHFW - Convener
2. Dr A. K. Shiva Kumar, Member National Advisory Council
3. Dr S. K. Satpathy, Deputy Commissioner (ID & AP), MOHFW

4. Dr V. K. Manchanda, DC, Maternal & Child Health, MOHFW
5. Shri T. V. Raman, Director Area Projects, MOHFW - Rapporteur
6. Dr O. Masee Bateman, Chief MCH & Urban Health, USAID/India
7. Dr C. S. Pandav, Professor & Head, Centre for Community Medicine, AIIMS
8. Dr Gurpreet Singh, In-charge MIS, IPP-VIII, MCD
9. Dr Siddharth Agarwal, Executive Director, Urban health Resource Centre
10. Dr Gauri Pada Dutta, Member, State Planning Board, West Bengal
11. Dr Mahavir Singh, Commissioner Ambala, Haryana
12. Dr Mala Ramachandran, Zonal Health Officer, Bangalore Municipal Corporation
13. Dr Nandita Kapadia Kundu, IHMP, Pune
14. Dr P. Padmanabhan, Joint Director (RCH), Directorate of Family Welfare, Government of Tamilnadu
15. Ms. Rekha Chauhan, Under Secretary, AP Division, MOHFW
16. Shri Subhash Kumar, AD (SS), MOHFW
17. Shri R. N. Yadav, DO, AP Division, MOHFW
18. Shri Sunil Kansal, Section Officer, AP Division, MOHFW
19. Dr Sanjeev Kumar Gupta, Professor, Centre for Community Medicine, AIIMS
20. Dr Karuna Singh, Project Director, IPP-VIII, MCD
21. Dr Sanjeev Upadhyaya, Consultant – Public Health, UHRC
22. Shri Anuj Srivastava, Urban Health Planning Specialist, UHRC
23. Ms Shivani Taneja, Consultant, UHRC
24. Dr. Roopa, Centre for Community Medicine, AIIMS



## Urban Health Proposal Development Process

The illustration depicts the recommended road map to development of urban health proposals for identified cities.



### Stakeholders' Consultations

There are multiple service-providers and stakeholders in a city. These represent government systems and civil society institutions and informal groups. The urban health proposal for the city should be built on the existing resources in the city (infrastructure as well as human). The involvement of the various stakeholders will enable the fulfillment of the below specified objectives.

#### *Objectives of Stakeholders' Consultations:*



- Identification of the stakeholders in the city: NGOs, Community based Organizations, and other partners who can play an active role in promoting urban health.
- Understand the present role and experiences of various stakeholders in improving the health of the urban poor and explore their possible roles in the urban health program.
- Constitution of an Urban Health Task Force at the state level and a city-level group as 'Urban Health Coordination Forum'. These platforms may be constituted under the chairpersonship of an appropriate official which will facilitate effective participation from the officials from the concerned departments.
- Strengthened mechanism for inter-sectoral coordination among various departments at the State/City and decentralized levels of the health centre.
- Develop program directions based on collective thinking and discussions between all groups so that concerned people develop a stake and ownership about the program.

### **Steps and key activities**

A series of consultations need to be conducted with the stakeholders involved:

#### **Public sector:**

- Department of Public Health (state-level, city-level and grass root functionaries)
- Urban Local Body (Municipal Corporation/ Municipality officials) – responsible for water supply, sanitation, drainage and overall governance issues. The meetings should include directly designate officials as well as elected ward members.
- District Urban Development Authority (DUDA)
- Department of Women and Child Development (State, city and grass root functionaries)
- Employees State Insurance Services (ESI)

#### **Private/Non-government sector:**

- NGOs, also agencies like IMA, IAP and FOGSI
- Community Based Organizations
- Private providers (like Private Practitioners – Registered/Unregistered, Traditional practitioners of Indian Systems of Medicine and Homeopathy, Charitable hospitals, Private for Profit Sector, Corporate sector).
- Private Nursing homes / hospitals

There may be certain meeting schedules decided between different levels (e.g. Anganwadi Workers with Supervisor, Medical Officers with Chief Medical Officer) which could be used as forums for small discussions. In addition, there will be a need to have specific individual meetings, small group meetings and large group consultations at all levels.

### **Situation Analysis**

An assessment of primary health care needs of the urban poor of the city, description of all existing health services run by public and private sector including non profit organizations along with their functional status and services being provided by them will be the critical information base for program development and planning.

### **Key Issues that need to be covered under this section:**

- **Development Indicators** pertaining to the cities [Slum Population (ward-wise if available), Density, Growth Rate, Literacy, etc.]
- **Indicators of MCH care** (ANC Coverage, Intra-natal Coverage, Nutritional Indicators, Morbidity Indicators, Family Planning Indicators, Reproductive Morbidity Indicators).
- **Health Facility Survey:** List of Govt. and Non Governmental (including Private for Profit Sector) Health Care Delivery Institutions in urban areas (Hospitals, Dispensary, UFWC, Health Posts, Anganwadi Centers, Nursing and Maternity Homes) with available Beds, Posts Sanctioned – Filled – Vacant, Facilities available, Equipment Supplied - Functioning / Not Functioning; services being provided and referral linkages, if any.
- **Utilization** of Govt. Services (ANC, Abortion / MTP, Treatment for Morbidity, FW services, Bed Turnover Rate, Bed Occupancy Ratio, OPD Attendance, Operations / Delivery Performed)
- Availability of Inventory Management Systems, Client Record Systems, IEC Materials
- **Behavioral Indicators** (Reasons for Non utilization of Services, Awareness on RCH / RTI / STI, Quality of Care at Service Delivery Centers)

### **Identification and mapping of target population**

This task involves the identification of underserved and unrecognized slums for better targeting of efforts. A map depicting the location of the urban slum population across the city, the major health providers and other stakeholders would be developed to guide the implementation plan and serve as a monitoring tool. This will help define the catchment areas for first tier Urban Health facilities (existing<sup>19</sup>, or newly proposed) and outreach of health to underserved slum areas.

The underserved and needy urban slum dwellers in each city will be identified to adequately target the needy for optimum impact. This will be done using available data and appropriate methods.

- Mapping of slums, major health providers (both Public and Private) and other urban health stakeholders on the city map
- Identification of the underserved slums including the ‘un-recognized’ settlements

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<sup>19</sup> Existing health facilities could be in the form of Urban Family Welfare Centers, Health Posts, Health Check Posts, State Allopathic Dispensaries, Civil Dispensaries or Post-partum Centers

- Categorization of slums based on different degrees of vulnerability to better target the program.

### **Steps and key activities**

Build a list of all slums. This could be done through accessing slum lists *viz.*; Municipal lists, Slum Clearance and Rehabilitation Act list, Slum lists from the District collector's/Magistrate's office, List at Mayor's office or prepared by any developmental agency. It is possible that these lists will not include unregistered poverty pockets, and these can be identified through site visits and discussions with local people.

Visit bastis of different levels of development to have a first hand understanding and infrastructure mapping (facility and manpower). Develop criteria to distinguish the neediest population based on available data from the Situational analyses. Classify urban slums and triangulate with stakeholders. On a city map, mark the location of all slums and health providers /facilities

## **APPENDIX-7**

### **Contact details of the Task Force Members for advising NRHM on strategies for Urban Health Care**

1. Shri B. P. Sharma  
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